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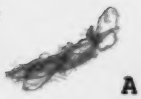
Child Maltreatment in Canada: A Developmental-Ecological Perspective

by

Diane Carolyn Reinke ©



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ABSTRACT

Studies from Canada and the United States show that children are at significant risk of being harmed by their parents or caregivers. Risk factors for child maltreatment have been explained using Belsky's ecological model. An extension of this model by Sobsey and Calder has identified factors which increase the risk for children with disabilities. In particular, cultural attitudes, beliefs, and values are risk factors which have not been thoroughly explained from a theoretical perspective in the disinhibition of violence against children with disabilities. In the first paper, Bandura's theory of moral disengagement is used to describe how attitudes, disability, and violence are linked. Cross-cultural implications for counselling families who have children with disabilities are also discussed.

In researching consequences of maltreatment, characteristics of individuals, such as age and disability status, have been mainly investigated using small, clinical samples. With the use of a representative Canadian sample of reported maltreatment cases, the second paper describes a study which investigates the proportions of children identified with behavioral, emotional, and cognitive clinical findings (not including the primary disability), and disabilities. It was found that behavior problem was the most common clinical finding in all age levels and the proportions of children identified as having various

clinical findings generally increased with age. Developmental delay was the most common disability in all age levels and the proportions of children identified as having various disabilities generally decreased with age. The third paper describes a study using the same Canadian data to compare children with and without disabilities on (a) the types of behavioral, emotional, and cognitive clinical findings, and (b) the proportions of these clinical findings across ages. It was found that behavior problem was the most common clinical finding identified for both children without and with disabilities in all age levels. Furthermore, children with disabilities were significantly more likely to be identified with various clinical findings than children without disabilities. The proportions of children with and without disabilities identified for various clinical findings generally increased with age. Implications for assessment, prevention, and intervention are discussed from a developmental-ecological perspective.

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CHAPTER 1

Introduction

Child maltreatment is a major problem in contemporary society (Garbarino, 1990). Too many children and youth are harmed by their parents or other caregivers (Statistics Canada, 1995; Wolfner & Gelles, 1993). Researchers confirm high rates of child maltreatment in many countries (Cohen & Warren, 1990; Trocme et al., 2001; Verdugo, Bermejo, & Fuertes, 1995). In fact, the World Health Organization has recently stated that child maltreatment is a serious global problem and calculated that 57,000 children are reported to die each year as a result of violence (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002). In May 2002, the United Nations General Assembly held a special meeting to determine the most important issues facing the world's children. Children from around the world and their advocates consistently identified violence as the most pressing issue (UNICEF, n.d.).

In order to establish a foundation for improving the quality of future policy and program efforts to address child maltreatment, researchers have examined two major areas: (a) risk factors for maltreatment, and (b) consequences of maltreatment (National Research Council, 1993).

Risk Factors for Maltreatment

Early research has examined individual risk factors including child, parental, and societal characteristics. Some explanations implicate the child in the etiology of

abuse; for example, the difficult (e.g., handicapped, premature or chronically sick) child has been portrayed as an elicitor of abuse (de Lissovoy, 1979; Hawkins & Duncan, 1985). Others have suggested that a child's normal behavior can elicit abusive reactions (Kadushin & Martin, 1981; Herrenkohl, Herrenkohl, & Egolf, 1983). Some researchers have indicated that abusive parents have a personality disorder or are mentally ill (McLeer, 1988; Spinetta & Rigler, 1972). Others have suggested that abusive parenting styles are learned (Parke & Collmer, 1975; Wolfe, 1987) or there is an intergenerational transmission (Egeland, Jacobitz, & Papatola, 1987). It has been proposed that abusive parents have inappropriate expectations of their children (Twentyman, Rohrbeck, & Amish, 1984). Elmer (1979) argued that abuse is a result of frustration because stress leads to excessive aggressive parenting. Societal norms and attitudes that tolerate or condone domestic violence can further influence the occurrence of maltreatment (Gil, 1971; Straus, Gelles, & Steinmetz, 1980). Since no single risk factor has been identified that provides a necessary or sufficient cause of child maltreatment, etiological models have developed from isolated cause-and-effect models to approaches that consider the combination of individual, family, environmental, and social or cultural risk factors that may contribute to child maltreatment (Ammerman & Hersen, 1990; National Research Council, 1993; Salzinger, 1999).

Belsky's ecological model

The most widely adopted model to explain the risk factors for child maltreatment is Belsky's (1980) ecological model. Belsky adapted Bronfenbrenner's (1977) ecological model of child development to address child maltreatment. His model considers a number of factors including the characteristics of the individual child, family, the nature of the local community, and the social and cultural environment. (See Chapter 5 for a discussion on Belsky's (1993) developmental-ecological model).

Sobsey and Calder's multifactorial model

Compared to children without disabilities, children with disabilities have been found to be at increased risk for maltreatment (American Psychological Association, 2003; Kendall-Tackett, 2002). Sullivan and Knutson (2000) calculated that children with disabilities are more than three times as likely to have a history of maltreatment as other children and that more than 30% of all children with disabilities have a history of maltreatment, compared to 9% of other children. Sobsey and Calder (1999) have extended Belsky's (1980) model and integrated elements of other theories and models to specifically address the maltreatment of children with disabilities. While Sobsey and Calder's multifactorial model has been acknowledged as the most comprehensive model for understanding violence against people with disabilities and has been widely adopted, it also remains largely untested (Petersilia, 2001).

Some elements of this model, such as characteristics of

children with disabilities and offenders, organizational environments, interpersonal relationships, and social agencies, have been studied more extensively. (See Chapter 2, pp. 25-27 for a summary). Other elements, however, particularly societal attitudes, values, and beliefs as contributors to risk, have not been examined as extensively. Specifically, there is a lack of research on if and how cultural attitudes, values, and beliefs about disability and children with disabilities increase the risk for maltreatment. Disinhibition has been proposed as a mechanism that links attitudes about disability and violence against children with disabilities. Sobsey and Calder (1999) suggest that widely held attitudes and beliefs about children with disabilities provide a rationale that helps potential offenders overcome normal inhibition that might otherwise prevent maltreatment.

Purposes of chapter two

In explaining the link between attitudes, disinhibition and violence, Bandura's (1990) theory of moral disengagement describes processes that disinhibit one's impulses to commit violence. Understanding these processes can clarify how children with disabilities are at risk for maltreatment, and inform counsellors of the necessity to evaluate their attitudes in order to develop ethical counselling practice in their work with families who have children with disabilities. Thus, the purposes of Chapter 2 are to (a) discuss the cultural attitudes, values, and beliefs of disability and children with disabilities; (b) describe the

processes involved in disinhibition of violence against children with disabilities by applying Bandura's (1990) mechanisms of moral disengagement; and (c) discuss counselling implications for working with families who have children with disabilities.

Consequences of Maltreatment

The second area of research in child maltreatment, which will be addressed in Chapters 3 and 4, addresses the consequences or effects of maltreatment. Clinicians and researchers have described the numerous effects of child abuse and neglect on the physical, psychological, cognitive, and behavioral development of children. Some physical consequences include bruises, broken bones, severe brain damage, disabilities, and death. (See Chapter 3, p. 86). Psychologically, children may experience low self-esteem, depression, anxiety, and a variety of other psychiatric symptoms or diagnoses. Cognitive effects of maltreatment involve attention problems, deficits in problem-solving, learning disorders, and poor academic performance. Examples of behaviors exhibited by maltreated children include withdrawal, sexualized behavior, running away, substance abuse, and violence (Miller-Perrin & Perrin, 1999; National Research Council, 1993). Recent advances in physiology and neuroimaging have helped identify the various biological bases, such as brain injuries, and changes in brain chemistry and development, for some of these behavioral responses among maltreated children (DeBellis et al., 1999a; DeBellis et al., 1999b; Ewing-Cobbs et al., 1998). It is

generally agreed among researchers and clinicians that child maltreatment can have many negative impacts on children's development (Garbarino, 1990).

Although research has suggested a relationship between child maltreatment and a variety of short- and long-term consequences, it is not clear how factors such as age, developmental status, or disability may influence the outcome of maltreatment experiences. Developmental psychology is based on the simple observation that children's behavioral, cognitive, and emotional functioning changes over time (Herbert, 2003). It is important to study developmental consequences of maltreatment in order to gain insight into basic processes of human development (Youngblade & Belsky, 1990).

Age

In order to properly understand the consequences of maltreatment on behavior, it is important to consider the implications of developmental changes over time. However, research on the effects of child maltreatment is often difficult to interpret because of one of two problems: (a) the results address too broad an age range, or (b) the results address too narrow an age range.

The first problem occurs when the results are reported for a broad age range of children. Research on the behavioral, cognitive, and emotional functioning of children that combines results for children in the age range 0 to 17 years potentially averages data and presents a composite that is not an accurate representation of any age group

(e.g., Eckenrode, Laird, & Doris, 1993; Goldston, Turnquist, & Knutson, 1989; Vissing, Straus, Gelles, & Harrop, 1991). Such research does not differentiate effects of maltreatment within the broad age range from infancy to late adolescence. For example, the incidence of sexually inappropriate behavior among pre-schoolers is different from adolescents and the definition of sexually inappropriate behavior changes across ages (Kendall-Tackett, Williams, & Finkelhor, 1993; Trickett & McBride-Chang, 1995). Thus, results of previous studies that average data over a broad age-range have limited value in understanding the needs and providing services to any specific age group.

The second problem occurs with the use of age ranges that are too narrow. Some researchers have used only preschoolers (Mian, Marton, & LeBaron, 1996), school-age children (Hibbard & Hartman, 1992), or adolescents (Cavaiola & Schiff, 1988). These studies investigate single age groups, typically use non-representative samples, and a small number of maltreatment effects with varying definitions. The results of studies that examine only one age group are difficult to compare or generalize to other age groups, since the research procedures lack uniformity. Thus, the research from only one age group has limited value in understanding the developmental differences over time.

Overall, the issue of age in maltreatment effects has been examined with a variety of age ranges, a limited number of maltreatment effects with inconsistent definitions, and small, clinical samples. Research requires a representative

sample of children with a broad range of ages that can be separated into specific age groups, and the use of numerous maltreatment effects with consistent definitions to compare across ages. Such methodological improvements would determine any differences between children and adolescents in the presentation of various maltreatment effects.

Disability

Widely held attitudes and beliefs assert attitudes that persons with disabilities are "damaged goods" and are insensitive to pain (Sobsey & Mansell, 1990). Consequently, disability status has not been examined as extensively as a factor in the consequences of maltreatment. When it has been considered, it has been mainly examined with children or adults who have specific types of disabilities, used a limited number of maltreatment effects that have varying definitions, and small, clinical samples or case studies (Balogh et al., 2001; Burke & Bedard, 1995; Varley, 1984). Such studies provide only limited information about the needs of children with and without disabilities. Research requires a representative sample of children and adolescents with a variety of disabilities and the use of many maltreatment effects with consistent definitions to compare children with and without disabilities across ages. These methodological improvements would determine any differences between children with and without disabilities across ages in the presentation of various maltreatment effects.

Purposes of chapter three

The Canadian Incidence Study (CIS) dataset provides a

unique opportunity to study the effects of age and disability in a nationally representative sample of children who were reported for maltreatment. The two studies described in Chapters 3 and 4 will use the Canadian Incidence Study (CIS) dataset. Chapter 3 describes and examines differences in the percentages of children at four age levels who have behavioral, emotional, physical, and cognitive clinical findings or disabilities. Differences among age levels provide information about how many children of different ages show various clinical findings and disabilities. Differences in the effects of maltreatment among the age levels have implications for the effective development and implementation of assessment, prevention, and intervention strategies to meet specific needs of maltreated children of different ages.

Purposes of chapter four

Brown's (2003) study with the CIS dataset to examine abuse of children with developmental delays only considered children with one type of disability and did not compare children with and without disabilities across ages on clinical findings. As an extension of Brown's study, Chapter 4 will (a) describe the types of behavioral, emotional, physical, and cognitive clinical findings among children with and without developmental disabilities, and (b) describe and examine the percentages of children with and without disabilities identified as having behavioral, emotional, and cognitive clinical findings in four age levels. Any similarities in the types of clinical findings

would further challenge the myth that persons with disabilities are insensitive to pain. Any differences in the percentages will provide knowledge of how many children with and without disabilities show various clinical findings in each age level. By examining clinical findings across ages, any differences would also provide information on concerns related to the development of children with and without disabilities. Furthermore, differences in the percentages will reflect the influence of individual characteristics, such as age and disability, in the consequences of maltreatment. These findings will have implications for assessment, prevention, and intervention strategies in meeting particular needs of maltreated children with and without disabilities of different ages. Taken together, the findings from Chapters 3 and 4 will provide necessary information to develop the types of strategies that help improve the quality of life of children who are reported for child maltreatment and exhibit various clinical findings.

Description of CIS Dataset

Although some information on consequences of maltreatment has come from American studies, there is a lack of research using Canadian data. The Canadian dataset used for the studies described in Chapters 3 and 4 was made available in 2002 and provides an opportunity to conduct research into the nature of child maltreatment in Canada. Its overall goal was to provide reliable estimates of the scope and characteristics of child maltreatment investigations. In particular, the CIS was designed to

examine (a) the rates of reported physical abuse, sexual abuse, neglect, emotional maltreatment, and multiple forms of maltreatment; (b) the severity (chronicity and evidence of harm/risk); (c) selected determinants of health for investigated children and their families and (d) to monitor short-term investigation outcomes, including substantiation rates, placement in care, use of child welfare court, and criminal prosecution (Trocme et al., 2001).

The CIS used a four-stage stratified sampling procedure designed to select a nationally representative sample of child welfare agencies which improves on past methodological limitations. In the first stage, there was a random selection of 51 sites from a national list of 327 child welfare service areas in Canada. The second sampling stage involved the selection of cases opened in each site over a 3-month period (October 1 to December 31, 1998), which resulted in 9909 case openings. Third, the opened cases were screened to identify those cases that met CIS definitions of suspected or reported maltreatment (n=5449). The final case selection stage involved identifying specific children who had been investigated for suspected child maltreatment which yielded a final sample of 7672 child investigations (Trocme et al., 2001). A full description of the sampling and data collection procedures are found in Trocme et al. (2001).

Child welfare workers used a Maltreatment Assessment Form consisting of three sections which described child, household, and case characteristics in detail. Various issues related to a child's functioning are similar to

issues described in the research literature. Behavioral, physical, emotional, and cognitive health issues identified in the CIS are described as "clinical findings" in Chapters 3 and 4. Clinical findings do not include the primary disability and include findings that might result from or be aggravated by maltreatment. Also, the CIS has disability information similar to disability information collected by Statistics Canada (2002). This allows for some rational comparison of the CIS with national statistics. The types of disabilities described in the studies in Chapters 3 and 4 are identified as physical, emotional, and cognitive health issues in the CIS.

A couple of limitations need to be discussed. The CIS dataset does not include cases of child abuse and neglect that were screened out, cases that were reported to only police, new incidents of maltreatment on open cases during data collection, and cases not reported to child welfare services. Any findings are applicable to known reported cases of maltreatment. Also, child welfare workers used certain instruments to collect the data that were not considered to be standardized. However, the workers had training in completing the instruments to improve their judgement on collecting information.

Despite these limitations, the CIS dataset is the first of its kind in Canada which reflects the current nature of child maltreatment in this nation. It provides a comprehensive picture of the characteristics of child maltreatment. Any research findings from this dataset would

directly apply to Canadian policy and program development and implementation regarding child welfare.

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CHAPTER 2

Attitudes, Disability, & Disinhibition

Introduction

Rate of Child Maltreatment

Child abuse and neglect is a human tragedy. It is estimated from Canadian and American data that at least 110 out of every 1000 children are victims of abusive violence each year (Statistics Canada, 1995; Wolfner & Gelles, 1993). This includes information about all types of maltreatment including physical and sexual abuse and various forms of neglect. These rates are also consistent with those from other countries suggesting generalizability across borders may be appropriate (e.g., Cohen & Warren, 1990; Verdugo, Bermejo, & Fuertes, 1995). According to the World Health Organization, 57,000 children under the age of 15 are reported to die from homicide annually and it is believed that unreported and misclassified cases would drastically increase this number (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002). Thus, a significant number of children are at risk for experiencing violence.

Risk and Vulnerability for Maltreatment among Children with Disabilities

Some children seem to be at greater risk for abuse and neglect than others. Specifically, children with disabilities are more likely to be abused than children without disabilities (Ammerman & Baladerian, 1993). Considerable evidence suggests that the presence of a disability can increase the risk of a child being abused (Ammerman, 1990). Risk refers to the likelihood of child maltreatment (Child Protection Consultation Services, 1996).

Vulnerability refers to personal or situational characteristics of a person, such as disability, that increase the risk of experiencing child maltreatment (Sobsey, 1994; Sobsey & Calder, 1999). Thus, the vulnerability of children with disabilities increases their risk for abuse and neglect (Ammerman, 1990; Child Protection Consultation Services, 1996; Sobsey, 1994; Sobsey & Calder, 1999).

Rationale and Objectives of the Paper

Considering the increased risk of maltreatment among children with disabilities, it is important to understand the multitude of risk factors as well as various mechanisms by which disinhibition of violence occurs. Specific risk factors, including cultural attitudes, values, and beliefs about disability and people with disabilities, are mechanisms that appear to disinhibit people's violent impulses against this population. Furthermore, it is important to understand how attitudes about disability and those with disabilities disinhibit violence against children with disabilities. Bandura's (1990) theory of moral disengagement provides a framework by which to understand the link between attitudes and disinhibition of violence against children with disabilities. Such an understanding can contribute to knowledge of how children with disabilities are at increased risk for maltreatment, inform professional and student counsellors of the importance of evaluating their own attitudes when working with families who have children with disabilities, and how to help these

families.

Thus, the objectives of this paper are (a) to briefly describe various risk factors in Sobsey's and Calder's (1999) model of multifactorial victimization of people with disabilities, (b) to discuss cultural aspects of this model as they relate to disinhibition of violence against children with disabilities, (c) to apply Bandura's theory of moral disengagement in explaining the link between attitudes, violence and disability, and (d) to discuss counselling implications for working with parents of children with disabilities.

Multifactorial Model of Victimization of People with Disabilities

A general summary of the factors that may account for increased risk follows. This summary is based on the multifactorial model of victimization (Sobsey & Calder, 1999). This multifactorial model is an elaboration of Bronfenbrenner's (1977) ecological model of child development that Belsky (1980) adapted to explain child abuse and Sobsey (1994) later adapted to explain violence against people with disabilities.

At the center of the model are child characteristics and behavior. Although all children are somewhat vulnerable to abuse because of a lack of self-defence skills, disabilities directly increase the risk for children of a given age. If a child cannot walk or cannot communicate, the risk of abuse increases because that child has more

difficulty defending himself, avoiding or escaping maltreatment, or getting assistance. As children mature, those with disabilities may not develop all of the skills that children without disabilities acquire to reduce the risk of abuse. Thus, the presence of a disability can directly affect a child's risk (Sobsey & Calder, 1999).

A child's risk for maltreatment also increases due to some indirect effects of a child's disability. These effects are a result of society's response to disability, and they may play a larger role than direct effects of disability in increasing risk. An example of an indirect effect is that special education programs commonly teach compliance and rely heavily on physical prompting that does not allow for the development of age-appropriate protection of personal space. Therefore, society teaches children with disabilities to use various behaviors that increase risk. These behaviors are not inherent to the child or the disability (Sobsey & Calder, 1999).

Offenders' characteristics are also a part of the model. Children with disabilities tend to have more caregivers and, thus, they are at greater risk for exposure to more potential offenders. This risk is further increased by the predatory caregivers who are attracted to human services because they provide access to vulnerable children, and by opportunistic caregivers who become abusive when they realize that they have access to vulnerable children in a system that offers little or no protection (Sobsey & Calder, 1999).

Organizational environments and interpersonal relationships also influence the risk for abuse. Children with disabilities are more likely to live outside their natural families in settings such as foster care, group homes, and institutions. Sometimes children with disabilities are placed together with adults or other children who are violent. Such clustering increases the risk for abuse. Isolation from families can also increase the risk (Sobsey & Calder, 1999). For instance, transportation providers who take children and adults to special programs have been reported as offenders in cases of sexual abuse and sexual assault (Sobsey & Doe, 1991). Such cases involve the isolation of a vulnerable person with an unknown driver for a time period.

Social agencies responsible for the protection of vulnerable people also play a role in increasing the risk. The failure of the criminal justice system to adequately investigate and prosecute crimes against people with disabilities implies that such crimes are not considered to be important, and these people are not considered to be worthy of protection. Furthermore, lack of coordination among child protection agencies and deliberate attempts to cover up abuse occurring in various institutions also increase the risk for abuse of people with disabilities (Sobsey & Calder, 1999).

Finally, cultural attitudes, values, and beliefs also appear to increase the risk for maltreatment of children with disabilities. One mechanism believed to link attitudes

with violence against children with disabilities is disinhibition (Sobsey & Calder, 1999).

Cultural Beliefs, Values, and Attitudes and Disinhibition

Culture exerts a powerful influence on how and what people think (Charlton, 1998; Kreps, 2000). People learn beliefs, values, and attitudes through socialization (Baron & Byrne, 1987). In the simplest terms, beliefs represent what people know; values represent what people feel. They constitute our attitudes which can influence behavior (French, 1996). Thus, attitudes, values, and beliefs play an important role in determining people's behavior, especially in encouraging or discouraging abuse and violence (Garbarino, 1987; Sobsey, 1994).

An important form of protection against abuse is acquired inhibition against violence. It is believed that most people learn to inhibit their violent and anti-social impulses through socialization. By adulthood, most have learned to control any violent or inappropriate impulses that are felt (Bandura, 1990; Grossman, 1995; Sobsey & Calder, 1999).

While some people experience little or no inhibition about harming others, many cases of violence happen because normal inhibition is weakened or overcome (Bandura, 1990; Grossman, 1995; Sobsey & Calder, 1999). Alcohol and some drugs can reduce inhibition (Wilens, Wyatt, & Spencer, 1998), and contribute to violence (Bond, 1998). Beliefs, values, and attitudes can also disinhibit violence because they provide rationalizations for justifying the offenses in

the offender's mind (Sobsey, 1994; Sundberg, Barbaree, & Marshall, 1991). Bandura's (1990) mechanisms of moral disengagement describe many psychosocial processes by which self-regulatory mechanisms or moral standards can be disengaged from inhumane conduct. These processes include reconstructing conduct as serving moral purposes, obscuring personal agency in detrimental activities, disregarding or misrepresenting the injurious effects of one's actions, or dehumanizing and blaming victims.

Therefore, inhibition can be broken down or morally disengaged as a result of mechanisms including devaluation, dehumanization, and blame. The remaining objectives of this paper are to (a) describe and illustrate these cognitive mechanisms, (b) review evidence for these mechanisms, (c) explain how these mechanisms, violence, and disability are linked using some of Bandura's mechanisms of moral disengagement, and (d) to discuss counselling implications for working with parents of children with disabilities.

Devaluation

Devaluation is a general term that includes those attitudes, beliefs, and actions that put a reduced value on a certain person or group of people (Sobsey, 1994). One justifies abusive behavior against another by using morally justifiable reasons, such as attributing inferior qualities to a victim, to devalue the victim's worth (Fattah, 1991). Devaluation of the quality of life plays an important part in disinhibition of violence against persons with

disabilities.

Devaluation involves how others perceive the quality of life for people with disabilities. It occurs when people assume that having a disability is incompatible with a good quality of life. In this paper, quality of life refers to the enjoyment of the life experience and the freedom from suffering (Sobsey, 1994). It involves a judgement about whether an individual can experience meaning in his or her life. Opinions are expressed on what makes a life valuable, meaningful, and worthy (Lusthaus, 1991). The potential for meaningful existence of a person with disabilities is then considered (Allen & Allen, 1979; Lusthaus, 1991). If it is deemed that a person can have meaningful quality of life, then that person's life is seen to have value. If it is deemed that a person cannot experience this quality of life because of the severity of the disability, then that person's life is seen as not having value (Lusthaus, 1991). The evaluation of one's quality of life is totally subjective (Sobsey, 1994). For example, Singer (1979; 2000) argues that people with disabilities, including severe disabilities, cannot have worthwhile and rewarding lives, and therefore their lives have less value. In his discussion on children with severe spina bifida, Singer stated "When the life of an infant will be so miserable as not to be worth living, if there are no 'extrinsic' reasons for keeping the infant alive -- like the feelings of the parents -- it is better that the child should be helped to die without further suffering" (2000, p. 188). He also stated

that "When the death of a disabled infant will lead to the birth of another infant with better prospects of a happy life, the total amount of happiness will be greater if the disabled infant is killed" (2000, p. 189). Such subjective evaluations of one's quality of life can influence disinhibition of violence.

Quality of Life, Moral Justification, and Disinhibition

People's attempts to make judgments about others' quality of life do not reveal anything about how those whose lives are judged value their own lives. Instead, people's attempts reveal how much they value others' lives (Sobsey & Wolbring, n.d.). When the quality of life of people with disabilities is presented as being very low or poor, suffering is seen as less important because the victims are portrayed as already having ruined or damaged lives. Furthermore, violence is disinhibited because it is justified as less harmful (Sobsey, 2002). For instance, Singer stated that it is morally wrong to allow people of any age with severe disabilities to live because their suffering is prolonged, they have limited or no potential for happiness, and they are using resources that might increase the happiness of others with a greater quality of life potential. Hence, Singer considers people with severe disabilities candidates for extermination. Because the quality of life is a disguised criterion of social worth (Sobsey & Wolbring, n.d.), the lives of people with disabilities are considered to have less value, they are often denied essential treatment, and are more likely to be

abused and mistreated. Thus, when quality of their lives is damaged, devaluation is confirmed and disinhibition of aggression continues (Sobsey, 1994).

Frazee (1998) stated that the nondisabled majority's perceptions about the experience of disability are very distorted; e.g., seeing disability as something greatly diminishing the quality of life. Because people are unable to imagine the experience of being disabled, a person with a disability is assumed to be living a tragic life marked by suffering and deprivation (Frazee, 1998). Thus, this person is assumed to be living a life of low quality. Murdering a person with a "low quality of life" is excused when the killer rationalizes or morally justifies this action as a release from suffering (Sobsey, 2002).

The death of Tracy Latimer at the hands of her father showed the gap between how people with disabilities perceive themselves and how they are perceived by people without disabilities. Many Canadians believed that her death was justified because people believed that Tracy's life had far less value than a nondisabled life (Frazee, 1998). Her case illustrates the social perception that the child is better off dead and that killing a person with severe disabilities is more like an assisted suicide, not murder (Frazee, 1998; Lambeth, 1998). One problem with this concept is that the decision to die is not made by the individual and it is not voluntary (Sobsey, 1994).

Tracy's case was viewed in similar terms as for a man who committed suicide because of his disabilities (Frazee,

1998). One critical difference is that Tracy Latimer did not have the ability to speak and therefore, she could not communicate her wishes to her father (Enns, 1999). It is assumed that people, who are unable to communicate their wishes, want to die. Also, the caregiver assumes they want to die and acts on this assumption (Enns, 1999). Accepting this argument is an indication of devaluing of Tracy's life (Lambeth, 1998). Robert Latimer argued that he was only trying to release his daughter from a life of constant pain and suffering and he was being unjustly punished (Enns, 1999; Lambeth, 1998). Schaffer indicated that the quality of life argument is a way to rationalize killing a child with a disability, but the real reason is to get rid of a child with a disability (Schaffer & Sobsey, 1991). In other words, a child with a disability has less social worth than one without a disability.

There has been the question of how the media portrayed Tracy's life. Language in print media portrayed her a certain way to justify her death and to relieve her father of any personal responsibility. The following section describes media examples of devaluation in Tracy's case.

Images and Language Illustrating Devaluation of Quality of Life

Many media images and descriptions of Tracy's life suggested suffering. Enns (1999) summarized various print media which used language to describe Tracy including "suffered from cerebral palsy since birth," "strapped to a wheelchair," "had many seizures," "needed constant care,"

and "couldn't walk, talk or feed herself." There was also a focus on her low level of mental ability, her need to be diapered, spoon fed, and provided with other personal care. Tracy was portrayed in the media as "damaged goods" and "less significant than the person who killed her" (p. 55). This language in the media suggested to the public that her quality of life was low. Furthermore, language used to describe Tracy's death included mercy killing, euthanasia, and assisted suicide (Enns, 1999). This language morally justified her death.

The support for Robert Latimer is in marked contrast to the public outrage at Susan Smith who drowned her two nondisabled children (Derksen, 1998). This public support for Robert Latimer may be explained as viewing Tracy's life as having far less value than a nondisabled life (Lambeth, 1998; Frazee, 1998). Like Robert Latimer, Susan Smith claimed that she killed her sons to prevent their suffering, but her claim was never taken seriously. Derksen stated that Tracy's disability mainly accounts for the difference in public opinion.

As shown with Tracy Latimer's case, the general misperception that life with a disability is an unending, unredeemable tragedy and not worth living results in a social environment in which people with disabilities are vulnerable and risk harm from those who care about them (Derksen, 1998).

The Other Side of the Quality of Life Argument

Hauerwas (1986) indicated that there is no objective

reason to believe that people with disabilities enjoy their lives less than anyone else, except that they are often badly treated by others. Furthermore, Derksen (1998) stated that "our lives are as precious to us as anyone's life can be. We experience happiness, grief, pleasure, pain, loneliness, and love just as all people do" (p. 50). In diaries of Tracy Latimer's mother, she described Tracy's good days when she ate and slept well and participated in school and family activities, playing, and making choices and being mischievous. There was evidence that her pain was periodic and treatable and Tracy was happy most of the time. This is in contrast to the media portrayals of Tracy's "constant pain and suffering" (Enns, 1999). Nonetheless, there are many people including family members, neighbours, service providers, doctors, and educators who do not share in the joys and gifts of a child who is disabled (Stewart, 1998).

Attitudes of Professionals

Attitudes of professionals can also be devaluating. Using the quality of life as a basis for defining the value of a person, his/her status as a human, and deciding who should live or die is common (Lusthaus, 1991). In 1977, Shaw, Randolf, and Manard reported that potential quality of life was the most important factor among physicians in making decisions about whether to treat infants with Down syndrome. Affleck (1980) reported that most physicians expect Down syndrome infants to experience a poor quality of life with little social value and view such expectations as

justification for letting them die. More recent research found that neonatologists are willing to discontinue life support for certain infants based on their concerns about the infants' quality of life (Wall & Partridge, 1997). In some cases, some professionals may recommend the options of institutionalization or euthanasia instead of encouraging the parents to love their child (Forest, 1991; Sobsey, 1994). Stewart (1998) described how his parents were told not to take him home because medical professionals could not see his life as being worth living. However, researchers have found that medical health-care professionals without disabilities consistently underestimated the quality of life of their patients with disabilities, and people with severe disabilities rated their quality of life virtually the same as nondisabled health-care professionals' quality of life (Bach & Campagnolo, 1992; Gerhart, Koziol-McLain, Lowenstein, & Whiteneck, 1994). These examples illustrate the devaluation process of judging the value of a life as low or poor quality. Such evaluations could encourage the disinhibition of violence by using devaluation as a rationale for such actions as was done in Tracy Latimer's case.

Applying Bandura's Mechanisms of Moral Disengagement to Devaluation

Mechanisms related to the cognitive reconstruction of one's behavior have relevance to explaining violence against persons with disabilities. According to Bandura (1990), cognitive reconstruction makes culpable behavior honorable.

In this process, destructive conduct is made personally and socially acceptable by portraying it as being done for moral reasons. People then act on a moral imperative. Devaluation is an example of this process, whereby one cognitively justifies actions on moral grounds, such as low quality of life. The disabled recipient of aggression is viewed as having a less than meaningful life and disinhibition occurs because nothing of significant value is damaged by the aggression.

Furthermore, language shapes the thoughts on which people base their actions. Activities can take on a different appearance depending on what they are called. Destructive conduct is made to appear benign and people who engage in it are relieved of a sense of personal agency (Bandura, 1990). In cases of people with disabilities, language such as euthanasia, mercy killings, or assisted suicide changes the meaning of a destructive act to a respectful act. Thus, justification on moral grounds and use of language are examples of processes used to disinhibit violence against people with disabilities.

Dehumanization

Dehumanization involves the attitudes, beliefs, and actions associated with treating a person or group of people as less than human (Sobsey, 1994). The "less than human" person or group of people, particularly those with disabilities, are viewed as different from others (Bogdan & Taylor, 1976; Goffman, 1997; Goldson, 2001; Lusthaus, 1991).

They are also viewed as not having the same needs, desires, feelings, and rights as others (Goldson, 2001). Differences in individuals are perceived as being "bad" or deviant rather than being accepted and valued (Goldson, 2001). As a result of perceived social deviance, disabilities become, not objective conditions, but rather concepts that exist in the minds of people who attach labels to others (Bogdan & Taylor, 1994; Davis, 1997; Taylor, 2000).

In addition, disability can carry a stigma (Taylor, 2000). Stigma is an extreme form of labelling and it concerns deviance from a society's expected norm. Stigma refers to a variety of socially inferior or deviant attributes that are permanently ascribed to a group or an individual (Johnstone, 1998). Thus, a stigma is not merely a difference, but a characteristic that is deeply discrediting to a person's moral character (Goffman, 1997; Taylor, 2000). Thus, a stigmatized person is one who is thought of as less than human or normal (Goffman, 1997). Because people with disabilities are viewed as less than human, they are stigmatized as a group (Johnstone, 1998).

The result of this dehumanizing process is a form of social distancing (Goldson, 2001). An increase in social distance results in disinhibition (Sobsey, 1994). Dehumanization and objectification (e.g., viewing persons as objects) are two methods of depersonalization (Sobsey, 1998). Depersonalization refers to the process of viewing people as nonpersons. Being human and being a person are not always considered to be the same (Singer, 1994). According

to Fletcher, a bioethicist, "any individual of the species homo sapiens who falls below the I.Q. 40-mark in a standard Stanford-Binet test, amplified if you like by other tests, is questionably a person; below the 20-mark, is not a person" (1972, p. 1). Singer also presented his practical qualifications of being a person by saying "killing a defective infant is not morally equivalent to killing a person" (1979, p.138; 2000, p. 193). Singer stated that being human refers to being a member of the species Homo Sapiens whereas being a person involves characteristics including rationality, autonomy, and self-consciousness (Singer, 1994; 2000). Singer (1994) also suggests that some nonhuman animals may be considered to be persons because they possess these characteristics. Therefore, nonpersons may be considered human, or part of the homo sapiens race, but they are not considered to be equals who are entitled to the rights and protections of persons. The following are examples of how persons with disabilities are seen as less than human.

Images and Language Illustrating Dehumanization

There are several examples showing that people with disabilities are sometimes dehumanized. In print media coverage of Tracy Latimer's case, there was rarely any mention of her accomplishments, her likes, dislikes, her interactions with others, her playfulness and smiles, or any other human qualities. Such omission prevented the public from seeing anything else about her, especially from seeing her as a human being (Enns, 1999). Charlton (1998) indicated

that the dehumanization of disability is clearly demonstrated in the media through telethons where people, especially children, are portrayed as cripples, not humans. When people with disabilities are portrayed in a positive or "successful" way, it typically involves an unrealistic miracle cure for their disabilities and leading a "normal" life (Charlton, 1998).

These images merge with language used to describe people with disabilities (Charlton, 1998). In the early 20th century, people with mental disabilities were often described as animals, vegetables, or waste products (Lusthaus, 1991; Wolfensberger; 1975). Even today, people with mental retardation are labelled with terms that suggest their less than human status (Lusthaus, 1991). For example, "retard," "invalid," and "cripple" suggest dehumanization (Charlton, 1998). English (1977) indicated that researchers have found such terms to have a stigmatizing effect. Studies have shown how people with disabilities are stigmatized and rejected by society (Bogdan & Taylor, 1994; Coleman, 1997; Goffman, 1997). Thus, the dehumanization of people with disabilities through language illustrates that disabled people are constantly told by the dominant culture what they can and cannot do and what their place is in society (Charlton, 1998).

Professionals also have been found to dehumanize children with disabilities through the use of language. It was found that staff of neonatal units used terms such as "nonviables" or "fetuses" to describe newborns with severe

disabilities in danger of dying, "chronics" to describe those born with disabilities whom they believe will survive, and "babies" or "good babies" to describe infants without disabilities (Bogdan, Brown, & Foster, 1992). These terms and the attitudes associated with them may have significant effects on parental attachment to children and can influence the quality and quantity of future parent-child interactions (Sobsey, 1994). Labelling or stigmatizing can disrupt attachment by increasing the emotional distance or breaking the emotional bond between parent and child. Such labels also increase perceived deviance of the person and social distance (Sobsey, 1994).

Parents may also feel differently because they have children who are perceived as different. Reactions of friends and other family members may reinforce the perceived deviance of the child. As a result, friends and other family members may distance themselves from the family. This distance can contribute to a lack of social support and isolation (Seligman & Darling, 1997).

Research on the effects of labels on attitudes indicates that people hold more positive attitudes toward those labelled as having learning difficulties or challenging behavior compared to those labelled as having mental subnormalities, mental handicaps, mental retardation, or behavior problems (Eayrs, Ellis, & Jones, 1993; Hastings & Remington, 1993). These researchers concluded that all the terms carried negative connotations, and yet specific labels negatively influenced attitudes. More recent research

indicates that providing information or education about these labels can improve attitudes (MacDonald & MacIntyre, 1999; Osterholm, 2001).

Research on social distance or the level of acceptable intimacy suggests a hierarchy of acceptable intimacy of various disabilities which remained stable across time and populations (Horne & Ricciardo, 1988; Resnick, 1984; Tolor & Geller, 1987; Tripp, 1988). Generally, physical disabilities were ranked as more acceptable in terms of level of intimacy compared to sensorimotor, intellectual, mental, emotional, functional, and psychoeducational disabilities. Even though it appears that a stable hierarchy exists, these studies have been criticized for their use of different lists of disabilities, for having missing or vague disabling conditions, and for their use of different measures of social distance (Olkin & Howson, 1994).

With methodological improvements, Olkin and Howson (1994) found that university students and social service employees showed a stable hierarchy whereby physical disabilities were ranked on acceptability. This hierarchy indicated a greater acceptance or less social distance of certain physical disabilities (e.g., amputee, blindness) compared to others (e.g., cerebral palsy, facial disfigurement). These results on the stigma hierarchy are consistent with previous research. Overall, these results suggest that labels influence social distance of various disabilities. Greater social distance confirms perceived differences of disabilities and reinforces the view of

dehumanization (Sobsey, 1994). As a result, disinhibition is likely because dehumanization becomes a rationale for violence.

Dehumanization as a Rationale for Violence

Dehumanization has been identified as an important factor in encouraging stigmatization, disrupting attachment, increasing perceived differences, and magnifying perceived social distance. It provides a rationale for committing violence against those with disabilities, and it erodes normal inhibitions against violence (Garbarino, 1987; Senn, 1988; Sobsey, 1994; Sullivan, Vernon, & Scanlan, 1987).

A specific example of dehumanization as a rationale for committing violence against someone with disabilities is the belief that disabled people do not experience pain or suffering (Goldson, 2001; Sobsey, 1994) as others experience them. In sexual offenses against people with mental retardation, victims are seen as incapable of understanding the sexual offense that they experienced. Because these victims do not fully understand what has happened, victims are perceived to be incapable of suffering compared to those without mental retardation (Sobsey & Mansell, 1990). Hence, offenders' actions are justified, the burden of guilt is removed, and disinhibition occurs (Sobsey, 1994).

A review of professional and popular literature on pain experiences of people with developmental disabilities reveals a paradoxical contrast in portrayals. People with intellectual disabilities are portrayed both as suffering so greatly that the quality of their lives is ruined and yet

also portrayed as lacking the ability to suffer. For example, both the court records and popular media described Tracy Latimer, a twelve-year-old from Saskatchewan, as being in a vegetative state, a state defined by a lack of consciousness of pain and suffering, and as being continuously in agonizing pain. This paradoxical notion was exemplified by one op-ed commentary that described Tracy Latimer as a girl "who for all intents was a vegetable. But a vegetable which is in continual pain" (Hardin, 1994, p. A9).

Professional literature has also propagated the idea that people with developmental disabilities do not experience pain or suffering. As recently as 1991, Biersdorff presented evidence based on case studies and anecdotal observations that people with severe developmental disabilities actually are insensitive to pain. Recent empirical research, however, has found that people with disabilities show the same range of responses to pain as people without disabilities. For example, using specific measures of pain responses to a painful stimulus, Nader, Oberlander, Chambers, and Craig (2004) found that behavioral responses of children with autism were generally similar to the behavioral responses of children without autism. However, children with autism were found to have substantial facial pain reactivity to the pain stimulus which significantly exceeded the facial pain reactivity of children without autism. Facial activity was identified as a sensitive, specific index of pain in children, people with

communication difficulties, and people with significant neurological impairment. These researchers concluded that children with autism are at least as reactive to pain as children without autism.

Also contrary to the pain insensitivity myth, researchers have found that individuals with disabilities experience damaging effects of different types of violence which are very similar to the traumatic effects on other individuals (Macfarlane, 1994; Sullivan & Scanlan, 1990; Westcott, 1993). These results are similar to empirical findings on pain in children with autism. In sum, there is no empirical support for the myth that people with disabilities are insensitive to pain.

Applying Bandura's Mechanisms of Moral Disengagement to Dehumanization

In addition to devaluation, dehumanization has relevance to violence against people with disabilities. Dehumanization is one mechanism of the set of disengagement practices which operates on the targets of violence. Self-sanctions against cruel conduct can be disengaged by divesting people of human qualities. Once dehumanized, the potential victims are no longer viewed as persons with feelings, hopes and concerns, but as subhumans. Furthermore, subhumans are regarded as insensitive to maltreatment and capable of being influenced only by severe methods. Dehumanized persons are treated much more harshly and when the maltreatment fails to achieve the desired result, this outcome is viewed as further evidence of their dehumanized

status. Thus, maltreatment against persons divested of human qualities is justified (Bandura, 1990).

Because people with disabilities are viewed as different, less than human, or not quite human or normal, they are viewed as not entitled to be treated like other humans. Living in institutions without adequate care, many people with disabilities display atypical behavior in response to maltreatment by caregivers. Such "subhuman" behavior as a result of abusive treatment is viewed as more evidence of their dehumanized status and reinforces more maltreatment (Sobsey, 1994). Dehumanization also confirms their devalued status in society, as shown with Tracy Latimer. Thus, viewing a person with disabilities as less than human and justifying his/her maltreatment based on dehumanization are examples of mechanisms used to disinhibit violence against people with disabilities.

Blame

Victim-blaming is a process by which potential victims are viewed as provoking the offender to harm them and as deserving of the actions committed against them. Offenders justify their actions in this way to eliminate any sense of personal responsibility for their actions (Fattah, 1991). Children with disabilities are often blamed for their own problems and for the problems of those around them (Sobsey, 1994; 2002).

Abuse-Provoking Characteristics

There has been some discussion and research in the past

which focused on the child's role in contributing to child maltreatment. Children, especially premature infants, were often seen as provoking maltreatment by their parents by problem behavior, such as excessive and difficult to manage crying. Such behavior was thought to trigger abusive incidents (de Lissovoy, 1979; Frodi, 1981). These "abuse-provoking" justifications ignore the cycle where a child's behavior may be in response to the maltreatment received (Ammerman, 1991). Furthermore, children with disabilities may exhibit behavior related to their disability as a way to communicate their needs. Their caregivers may interpret this behavior as deviant or abuse-provoking and abuse their children (Rusch, Hall, & Griffin, 1986). Overall, research findings do not indicate that children are instrumental in the etiology of abuse (Ammerman, 1991).

Research also indicates that perpetrators tend to blame their victims for the abuse. Interviews with developmentally delayed women who were molested as children indicated that they were told directly or had perceived indirectly that their (step)fathers were not to blame for the abuse. Some reasons included: (a) their abusers were "sick" and thus, they were not responsible, (b) their families had not believed the victims and were angry at them for "imagining" or "fantasizing", and (c) their mothers and other family members blamed them for "seducing" their (step)fathers. Also, most women believed that their fathers were not adequately punished, because the women were perceived as "retarded" and "no one cares what happens to a retarded

person" (Cruz, Price-Williams, & Andron, 1988, p. 417). Thus, people with disabilities are also at risk for being blamed for their abuse.

Professionals are not immune to victim-blaming. Using hypothetical vignettes of father-daughter incest, recent research indicates that school professionals assigned significantly more blame to a child victim who was described as behaving in an encouraging manner compared to a child victim who was described as behaving in a passive and resistant manner. Although all professional groups assigned most of the blame to the father, they still assigned some degree of blame to the child. It was suggested that school professionals need current education on child sexual abuse accommodation syndrome and the importance of not attributing blame to victims regardless of their behavioral presentation (Ford, Schindler, & Medway, 2001).

Stress from Demands of Caregiving

Children are also blamed for the stress that is assumed to be created by their demands on caregivers (Ammerman, Van Hasselt, & Hersen, 1988; Seligman & Darling, 1997). The dependency-stress hypothesis proposes that children with disabilities are more dependent on their caregivers and, as a result, these children cause more stress for them and are abused by stressed caregivers (Sobsey, 1994). Research findings do not support this hypothesis (Musick, 1984; Pillemer & Finkelhor, 1989). Other research has shown that perceived stress in families who have children with multiple disabilities did not differentiate between those with and

without a history of child maltreatment (Benedict, Wulff, & White, 1992). These studies' results are contrary to the assumption of stress as being a major factor in maltreating children with disabilities.

Some professionals may be encouraging the assumption that all people with disabilities are burdens and sources of stress for their families. For example, physicians told parents of a "profoundly" brain damaged baby, "Don't bond with the baby - she will probably die, or at best be a burden to you for the rest of your life" (Forest, 1991, p. 400). Stewart (1998) stated that responsibilities of raising a child with a disability are viewed as too great and parents are told what super-human qualities they must have to carry out such a task. These examples illustrate how professionals can contribute to the blame process by viewing a child with disabilities as a burden or source of stress for parents.

In addition, parents may reject children with disabilities because of their own preexisting attitudes toward disability or because of attitudes of rejection expressed by others. Brazelton and Cramer (1990) suggested that the child's imperfection threatens the image of the parents and attachment may fail to develop because the child is not a source of pride, but has become the proof of parental failure. There are messages that imply children who are perfect will be loved, but children who are not perfect will be rejected (Forest, 1991). Such attitudes may further contribute to parents' expectations that raising a child

with disabilities is stressful and the child is to blame for parents' abusive behavior because of his/her imperfection.

The belief that children with disabilities are punishment for the sins of the parents also contributes to the maltreatment of these children (Morgan, 1987). Children who are viewed as a punishment are automatically cast into an extremely negative role. These children are expected to bring suffering to the parents and all parent-child interaction is viewed negatively. This encourages resentment of children with disabilities and such resentment could disengage as abusive behavior toward these children (Sobsey, 1994).

Applying Bandura's Mechanisms of Moral Disengagement to Blame

Like devaluation and dehumanization, blame also has relevance to violence against people with disabilities. It is another mechanism of the set of disengagement practices which operates on the targets of violence. Offenders' violent conduct is viewed as provoked by the victims. Any injurious conduct becomes a justifiable defensive reaction to such provocations. Victims are blamed for bringing suffering onto themselves. Thus, victims are derogated in this process. Blame gives rise to devaluation and indignation, which, in turn, provides moral justification for further maltreatment. Hence, blame that leads to devaluation and moral justification shows how the various disengagement mechanisms are interrelated and work together in weakening inhibitions (Bandura, 1990).

Persons with disabilities are especially vulnerable to the victim-blaming process because of their devalued and dehumanized status in society. Children with disabilities are blamed for causing problems due to others' perceptions of their abuse-provoking behaviors, demands on caregivers, and being proof of their parents' mistakes. Any maltreatment they experience is blamed on them, which further contributes to their devaluation and dehumanization. Continued maltreatment is morally justified through further victim-blaming.

Treatment versus Counselling

The previous discussion on devaluation, dehumanization, and victim-blaming illustrates how these cognitive mechanisms disinhibit violence against children with disabilities. Although most parents of children with disabilities do not maltreat their children, all families can be viewed as having some risk factors for child maltreatment. The risk associated with parenting a child with a disability can be seen as adding to the risk for families of children with disabilities. Not all, but some families of children with disabilities undergo processes that create excessive risk (Sobsey, 1994). Treatment may be required for some families that exhibit signs of family dysfunction, such as maltreatment or pathology, in order to change these behaviors into more healthy adaptive behaviors (Seligman & Darling, 1997).

Many families of children with disabilities undergo a

healthy adjustment process. Counselling may be helpful for all families of children with disabilities to support this adjustment process through strategies for healthy parenting and a focus on existing healthy life skills (Seligman & Darling, 1997). Also, counselling these families may involve cross-cultural counselling strategies because they may be different from the majority (Truscott & Crook, 2004). In order to counsel families of children with disabilities, counsellors need to understand mainstream or majority culture as a social phenomenon, disability as a subculture, and similarities and differences between disability culture and mainstream culture.

Counselling Implications

Culture, Disability, and Cross-Cultural Counselling

Culture is a complex social phenomenon that has powerful influences on all aspects of life (Charlton, 1998; Kreps, 2000). Culture consists of shared beliefs, values, and attitudes that guide the behaviors of members (Baron & Byrne, 1987; Kreps, 2000). It is the norms or accepted ways of behavior of a group of people; a body of common understandings or the collective ways that members of social groups make sense of their reality and deal with challenges (Kreps, 2000). People of different ages, educational levels, socioeconomic standings, occupations, and sexual orientations can be said to belong to their own cultural groups. Furthermore, persons who share specific physical, mental, and health conditions, such as people who are blind,

deaf, or paralyzed have their own cultural orientations (Kreps, 2000).

People with disabilities are likely to be considered as a minority culture, or a culture that may be different from mainstream culture (Truscott & Crook, 2004). Like other minority cultures, disability culture is faced with the paradox of attempting to celebrate its own uniqueness and simultaneously demanding full-inclusion in mainstream society. Unlike other minority cultures, parents of children with disabilities have the same attitudes, beliefs, and values about disability as the rest of society. Consequently, these parents may struggle with accepting their child because their natural instincts of attachment to their child are in conflict with society's and their own attitudes about disability.

Cross-cultural counselling requires that families of children with disabilities are legitimately viewed as being part of or being initiated into a new culture. For professional counsellors to move toward ethical cross-cultural practice, there needs to be a focus on four primary areas: (a) openness, (b) awareness, (c) knowledge, and (d) services (Truscott & Crook, 2004). Below is a general discussion of these areas in counselling practice organized in two groups followed by examples of these areas as they apply to counsellors in their professional development and their counselling work with parents of children who have disabilities.

Openness and Awareness of Counsellors' Attitudes

To be cross-culturally competent, counsellors first need to be willing to actively welcome different worldviews. That is, counsellors need to develop an attitude of openness toward other cultural views of the world and a tolerance for divergent views of right and wrong. When providing services to culturally diverse clients, counsellors need to be willing to accept that clients will not have the same worldview as them. Also, counsellors must tolerate the discomfort they feel when clients base their decisions on different standards than counsellors' standards. In essence, this is the ultimate expression of counsellors' respect for clients' dignity as persons. Although there will be an inevitable boundary crossing of personal beliefs, values, and attitudes into professional roles, having an open attitude is personally and professionally rewarding and ethical (Truscott & Crook, 2004).

Also, counsellors need to become more aware of their cultural attitudes, beliefs, and values about human behavior. Members of a dominant culture typically have no more than a superficial appreciation of a culture until they open their eyes to the experience of being a member of a minority culture. Gaining awareness of our own cultural attitudes, values, and beliefs can be done in several ways, including interviewing, living, or working with those of a minority culture. This awareness also involves how counsellors' personal attitudes, beliefs, and values influence their own behavior. Such awareness can influence

counselling practice with clients of a minority culture. Therefore, being open and aware of one's own and others' values, beliefs, and attitudes are the first steps in developing a cross-culturally competent practice (Truscott & Crook, 2004).

Parents Becoming Open and Aware of Attitudes about Disability

Because negative attitudes about people with disabilities are endemic to our society, all people share them to some extent. Most people hold both negative and positive beliefs about people with disabilities and other minorities. Positive beliefs and attitudes can delude people into thinking that they do not hold negative ones, but under certain circumstances, the negative attitudes and beliefs arise (Sobsey & Calder, 1999).

As previously discussed, various professionals hold negative attitudes toward disability and those with disabilities. For counsellors, it is important to be open and aware of personal attitudes, beliefs, and values and examine these aspects before working with a specific population. Counsellors' particular attitudes toward disability may influence counselling with parents in negative ways such as compromising objectivity with clients and reinforcing any negative messages demonstrated by other professionals. As a result, these negative influences compromise the clients' best interests and their needs may not be met (Seligman & Darling, 1997). Thus, there are several steps to consider prior to working with this

population.

The first step is to outline all possible attitudes, values, and beliefs about disability (Seligman & Darling, 1997). Several questions can be asked in outlining attitudes about disabilities and working with those who are disabled: (a) Are some disabilities more acceptable to you than others? (b) Can you accept all disabilities? (c) Are disabilities a flaw or are they part of one's identity? (d) Do you value those with disabilities? (e) Do you think that people with disabilities can contribute to society? (f) Do you see persons with disabilities as fully human or less than human?

The next step is to understand the origins of those attitudes and to begin challenging those attitudes by critically evaluating any evidence. Counsellors may reflect on how the media, other professionals, friends, and family influenced their attitudes by thinking about the kinds of messages they received about disability and people with disabilities from significant sources in their lives. Interviewing someone with disabilities or family members of a child with disabilities or providing factual information on disabilities may aid in changing counsellors' attitudes by educating them and providing them with evidence contrary to their attitudes, beliefs, and values (Seligman & Darling, 1997).

In cases of families who are at risk for maltreating their children with disabilities, counsellors also need to be aware of and understand the dynamics of violence (e.g.,

child sexual abuse accommodation syndrome, lack of social support, and substance use), and how attitudes toward those with disabilities may increase the risk of violence. It is important not to blame the child nor parents for the situation, but to understand what may be involved in disinhibition of abuse (Ford et al., 2001; Seligman & Darling, 1997). Furthermore, counsellors need to be aware of possible situations where a child may need to be removed from the home. (See Chapter 5 for a discussion of this issue.)

This evaluation process may begin during counsellor training, supervision, and workshops, and continue throughout a professional counsellor's career. Such a process may contribute to development of a comfort level in working with those with disabilities and issues around disability, including dynamics of violence. Therefore, openness, awareness, and evaluation of attitudes is an important step in understanding culture and disability, and developing tolerance and acceptance of disability to help families with children with disabilities make healthy adjustments to their situation.

Culturally Appropriate Knowledge and Services in Counselling Practice

The third area of cross-culturally competent practice involves knowledge of other cultures, particularly the attitudes, beliefs, and values about behavior arising out of the various cultures within Canadian Society. This knowledge is especially important when clients are struggling between

the expectations of their own culture and those of the majority. Skills in noticing body language and tone of voice, making eye contact, having tolerance for confrontation can be critical when providing services to persons who may be different from the majority. Thus, an ethical counselling psychologist will strive to gain knowledge about the culture of clients who are being served in order to best meet their needs (Truscott & Crook, 2004).

Such knowledge can further aid counsellors to develop services that are appropriate to the clients' needs, the final area of cross-culturally competent practice. Standard interventions or assessment instruments do not sufficiently address the needs of persons from minority cultures. In particular, counsellors should be willing to involve support people from clients' cultural group and to make appropriate referrals based on clients' needs. This may involve a referral to a counsellor or other appropriate professional who is knowledgeable and skilled regarding a client's needs. It may also be appropriate to consult with an expert from the client's culture who may or may not be a psychologist. Thus, knowledge of a variety of services is important in order to effectively meet the needs of clients who may be different from the majority (Truscott & Crook, 2004).

Applying Knowledge and Services to Counselling Parents of Children with Disabilities

Counsellors familiar with their attitudes about disability, knowledgeable about disability as a minority culture, clients' needs, and various available services can

help this population in many ways. Parents who are struggling with their attitudes, beliefs, and values and those of the majority in raising a child with disabilities require a cross-culturally competent counsellor who can help them clarify their situation and needs. Because parents' needs, attitudes, beliefs, values, and reactions to their child will vary, counsellors need to be flexible with approaches when working with parents of children with disabilities. Each family situation must be realistically addressed with sensitivity and various approaches should be considered to best meet each family's needs (Seligman & Darling, 1997; Singer & Irvin, 1991). The following paragraphs describe various ways to counsel parents of children with disabilities.

Redefining attitudes

First, counsellors can help parents explore and clarify their attitudes toward disability (Seligman & Darling, 1997). For instance, parents with a newly diagnosed child may view disability as bad, evil, a punishment for their sins, a representation of failure as parents, or a circumstance that is beyond their control. They may hold devaluing and dehumanizing attitudes, such as that their child with a disability is not perfect, is unworthy, or is less than human. Parents need to understand that accepting the stigma of a child with a disability could increase the risk of maltreatment (Fewell & Gelb, 1983).

Counsellors may help these parents redefine their attitudes by listening to their views and their concerns

about having a disabled child (Seligman & Darling, 1997). Parents' views and concerns are often based on other people's reactions or lack of information (Rubin & Quinn-Curran, 1983; Singer, 1993). It is important not to minimize their concerns, but make them part of the change process (Affleck & Tennen, 1993). This process can be done by having parents write out all their attitudes, thoughts, and feelings about disability and discuss them with a counsellor in family sessions or within a group setting with other parents who have children with disabilities. By doing so, parents can understand where their attitudes originated, such as with the media, friends, family, or other professionals. Those attitudes could be challenged by examining evidence using information on the realities of disabilities and connections with other parents of children with disabilities (Boss, 1993; Seligman & Darling, 1997). Such examination could provide the first step to redefining their attitudes.

Reframing parents' experience

After helping parents redefine their attitudes, counsellors can help parents reframe the experience of having a child with a disability (Seligman & Darling, 1997; Singer & Irvin, 1991). There are several ways to accomplish this task. One strategy is to provide a context of choice or range of potential outcomes to their situation (Scorgie & Sobsey, 2000; Sobsey, 1997). This strategy can be applied by helping parents regain a sense of control or mastery. For instance, parents of hospitalized medically fragile infants

could visit frequently, provide social and tactile stimulation, pray, and monitor their child's medical care to gain a sense of control (Affleck & Tennen, 1993). Parents of children with developmental disabilities could be involved in their child's school program, training activities, support and advocacy groups, and seek professional support (Heller, 1993). Parents of children with severe disabilities may require individualized forms of counselling, in-home assistance, and long-term group support (Singer, 1993). Discussing ranges of outcomes can illustrate to parents that they can do things to experience their situation as fully as possible. Thus, counsellors can help parents recognize what can and cannot be controlled in their situations and identify realistic tasks that are appropriate to their situation (Boss, 1993).

Another way to reframe parents' experience through presentation of choices is by presenting parents with choices in how they react and adapt to having a child with a disability. For example, parents with a newly diagnosed child could be presented with the choice of seeing their child with a disability as a stress or burden in their lives or as an opportunity to adapt and learn about themselves and relationships. Parents need to be permitted and encouraged to love their children as they are (Lusthaus & Lusthaus, 1993). By spending time with their child and focusing on the positive aspects of the child's personality and behavior, such as smiling and laughter, parents can learn to minimize the child's limitations or health problems (Patterson, 1993;

Ziolko, 1993). As the child becomes older, parents will see personality and behavioral traits which they enjoy (Lusthaus & Lusthaus, 1993; Patterson, 1993). Celebrating a child's gifts and benefits can be done through documentation of enjoyable times in family activities, acknowledging the child by smiling or hugging when the child displays positive traits, listing the child's positive qualities, and discussing ways in which the child has benefitted the family as a whole. These activities may help facilitate attachment between parents and child (Lusthaus & Lusthaus, 1993; Seligman & Darling, 1997). Parent groups can also help in reframing the experience by discussing each child's gifts and benefits (Seligman & Darling, 1997).

Another example of choosing how to react and adapt to having a child with a disability involves parents discussing each other's definitions of their situation and the meaning it has for them (Affleck & Tennen, 1993; Boss, 1993; Singer & Irvin, 1991). This process brings forth similarities and differences in viewpoints about their situation and disability (Singer & Irvin, 1991). Once these viewpoints are voiced, parents with a newly diagnosed child or parents at risk of maltreating their children with disabilities can attribute shared meanings to their situation (Boss, 1993; Singer & Irvin, 1991). Some parents may find meaning through their religious beliefs (Affleck & Tennen, 1993; Singer & Irvin, 1991). Also, families' participation in parent groups with experience in this process could help in understanding others' viewpoints and meanings of their situations (Boss,

1993; Singer & Irvin, 1991). Thus, such discussions may aid in seeing the value in having a child with a disability (Singer & Irvin, 1991). Overall, these strategies in presenting choices provide a way to view exceptional or unexpected circumstances in a unique way.

Redefining roles is another aspect in reframing parents' experience (Patterson, 1993). Parents may believe that they need to be totally devoted to their child with disabilities and be super-parents (Fewell & Gelb, 1983). It is important to help them find a balance in their roles to prevent burnout and isolation from others (Rubin & Quinn-Curran, 1983; Seligman & Darling, 1997). Families who have children with disabilities and limited social support may be at particular risk for maltreating their children because of the isolation (Sobsey, 1994). Such families may not know how to adequately divide caretaking tasks. Family members can learn to assign work at family meetings, parents can learn to use a reward system to motivate siblings to assist with family tasks, and arrange joint parenting tasks (Seligman & Darling, 1997; Singer & Irvin, 1991; Sobsey, 1997). Counsellors can also help parents identify parental tasks (e.g., bathing, feeding) and recognize over-tasking (e.g., performing physical therapy) in redefining their roles (Sobsey, 1997). Parents also need to recognize their need to set limits and take care of their needs through personal leisure activities (Lusthaus & Lusthaus, 1993). Respite care or other parents from parent networks in the community could also help alleviate over-tasking, provide a balance, and

decrease isolation (Seligman & Darling, 1997; Singer & Irvin, 1991).

Utilizing social support networks

Counsellors can also assess the availability and types of social support systems of families who have children with disabilities. Trute and Hauch (1988a; 1988b) have found that families' successful adaptation to the birth of a child with developmental disabilities appeared to be linked to the use of family and friends as social support. Specifically, family members were the main resource for material aid needs, physical assistance, and respite care. Both family and friends were sought for emotional support, advice and information, and social participation; however, more friends were sought for these types of social support. These researchers concluded that parents of children with disabilities may benefit from counselling on mobilizing, accessing, and using social support networks.

Empowering clients

It is important that counsellors do not pathologize the family, by helping parents to identify strengths and provide a sense of empowerment (Seligman & Darling, 1997; Singer, 1993; Ziolko, 1993). Counsellors should avoid "catastrophizing" the possible effects of having a child with disabilities and they should not assume that there will be inevitable ongoing stress in these families (Scorgie & Sobsey, 2000; Trute, 1990). Parents of children with disabilities at risk for maltreatment may see something wrong with themselves and have negative views of

counselling. Few families will require treatment but most will benefit from counselling (Seligman & Darling, 1997; Singer, 1993). Counsellors need to reframe the counselling experience as a venue to discuss options, feelings, strengths, instead of what is wrong with the family (Singer & Irvin, 1991; Ziolko, 1993). For instance, some parents with a newly diagnosed child may identify their family as having an illness and not see themselves as a family with strengths (Patterson, 1993). Counsellors may suggest each family member write, discuss, draw, or make a collage of other family members and their traits. Such an exercise could aid them in seeing their family in a larger context.

Another way for parents of children with disabilities at risk for maltreatment to empower themselves is to learn basic cognitive and behavioral skills. Self-monitoring of stressors, identifying and changing automatic negative thoughts, progressive muscle relaxation or other relaxation techniques, monitoring and expanding social support, increasing pleasant activities, and time management can help empower parents by making perceived stress manageable. Such strategies can be learned in group or family counselling settings (Seligman & Darling, 1997; Singer, 1993; Singer & Irvin, 1991). These strategies do not presume pathology, but they are normal processes that are helpful to many others in difficult circumstances (Singer & Irvin, 1991).

Parents of older children with disabilities at risk for maltreatment can also empower themselves by focusing on their progress and past successes in stressful times

(Lusthaus & Lusthaus, 1993). They may begin this process by discussing and documenting stressful events, their reactions, and ways in which they have dealt with those events (Singer & Irvin, 1991). They also can begin writing, refer back to a diary or photo album of enjoyable times, and engage their social support network (Lusthaus & Lusthaus, 1993; Singer & Irvin, 1991). Thus, counsellors can help these parents focus on exceptions and learned experiences to guide their process.

In addition, counsellors helping parents build plans of action to deal with potential problems can provide a sense of empowerment, instead of blaming the child and viewing their situation as hopelessly filled with problems (Ziolko, 1993). Various skills are important for families who have children with disabilities at risk for abuse, including communication skills, problem-solving skills, and nonabusive behavior management (Singer & Irvin, 1991; Sobsey, 1994). These skills can be learned in group settings, with other parents, in family counselling settings, and practiced in real-life situations (Singer & Irvin, 1991). Group discussions of the practiced skills can provide the opportunity for parents to give feedback and support (Singer & Irvin, 1991). Hospitals, schools, and community agencies may have services for parents that provide information on new services and technologies, referrals, and advocacy and group support which are beneficial for parents at risk of maltreating their children with disabilities (Singer, 1993; Singer & Irvin, 1991). Networking with different social

supports is important in preventing maltreatment of children with disabilities (Sobsey, 1994).

Modeling positive behavior

Throughout the counselling process, counsellors need to show and model respect, tolerance, acceptance, and understanding for the child (Scorgie & Sobsey, 2000; Seligman & Darling, 1997; Sobsey, 1997). Counsellors can demonstrate these qualities by their language, acknowledging concerns and strengths within the family, and providing the family with support, alternatives to their thinking, and referrals (Seligman & Darling, 1997). When possible, counsellors can interact with the child with disabilities by making eye contact, saying the child's name, holding the child, and including the child in specific activities during counselling (Ziolko, 1993). Such a demonstration by the counsellor shows ethical and competent counselling and a way for parents to apply newly acquired knowledge or encouragement to continue to do so (Sobsey, 1997).

Summary

Children with disabilities are at greater risk than other children for maltreatment. The multifactorial model of victimization identifies many risk factors involved in the increased risk among children with disabilities, including the majority culture's attitudes toward disability and people with disabilities. Disinhibition was discussed as one mechanism which links attitudes and maltreatment of children with disabilities. Specifically, devaluation,

dehumanization, and blame were discussed as mechanisms which disinhibit violence against those with disabilities. Bandura's mechanisms of moral disengagement provide a framework to understand the link between these mechanisms, disability, and violence.

Devaluation of quality of life is a mechanism by which the victim's worth is reduced. In cases involving people with disabilities, such as Tracy Latimer, the perceived lack of quality of life has been argued as a rationale to commit murder (Enns, 1999). Tracy Latimer's case illustrated how moral justification and language to change the meaning of her murder contributed to the disinhibition of violence. Moral justification and language are disengagement practices which operate on behavior.

Dehumanization is another disengagement mechanism whereby the victim is viewed as less than human. People with disabilities are dehumanized through language, labels or stigma, and perceived differences. As a result, social distance is created which allows for disinhibition of violence to occur. Bandura discussed dehumanization as a mechanism which centred on the victims, and repeated violence occurs because their devalued and dehumanized status is reinforced by their behavior.

Blame was the last mechanism discussed and it refers to the attribution of blame onto the victims for the maltreatment they received. Children with disabilities are blamed for their suffering because they are seen as displaying provoking behavior, being stressful for

caregivers, and being viewed as punishment for their parents' mistakes. Attributing blame onto the victim further devalues the victim and provides justification for more maltreatment. Blame, as indicated by Bandura, gives rise to devaluation and moral justification. Thus, Bandura's mechanisms are not mutually exclusive.

The four primary areas of cross-culturally competent counselling are applicable to working with families who have children with disabilities. Considering the importance of attitudes in the disinhibition of violence against people with disabilities, counsellors must be open and aware of their attitudes and evaluate them before working with parents of children with disabilities. Counsellors also require to be knowledgeable of disability as a minority culture, the needs of clients from this culture, and a variety of appropriate services to meet these clients' needs. Thus, counselling parents involves evaluation and refinement of their attitudes toward their child with disabilities; reframing their situation through presentation of choices; redefining roles; utilizing social support networks; and building a sense of empowerment by identifying strengths, learning basic cognitive behavioral strategies, focusing on progress, and acquiring life skills. Counsellors also need to be realistic, demonstrate tolerance, understanding, and flexibility when working with these families.

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CHAPTER 3

Age Effects of Reported Child Maltreatment in a Canadian Sample of Children and Adolescents

Introduction

Since seriousness of child maltreatment has been acknowledged as a public health issue, there has been considerable attention to the physical, mental, emotional, and social effects of child maltreatment (Kaplan, Pelcovitz, & Labruna, 1999). Generally, when compared to non-maltreated children and adolescents, maltreated children and adolescents exhibit a wide range of problems: (a) school or academic difficulties (Eckenrode, Laird, & Doris, 1993); (b) psychiatric symptoms or diagnoses such as depression, anxiety, and conduct disorders (Flisher, Kramer, Hoven, & Greenwald, 1997; McLeer et al., 1998); (c) aggression or delinquent behavior (Vissing, Straus, Gelles, & Harrop, 1991); (d) high risk behaviors including substance use (Arellano, 1996), running away (Goldston, Turnquist, & Knutson, 1989), and sexually inappropriate behavior (Goldston et al., 1989; McClellan, McCurry, Ronnei, & Adams, 1996); and, (e) self- and other-directed destructive behaviors (Stone, 1993; Taussig & Litrownik, 1997). Overall, these findings support the hypothesis that maltreatment leads to adverse effects for children and adolescents. However, differences in maltreatment effects across ages are not clear from these studies because of methodological shortcomings, including inconsistent measures and number of maltreatment effects examined, lack of representative samples or appropriate control groups, and use of a wide range of ages which may not distinguish the effects of maltreatment for younger and older children

and adolescents. Therefore, the purpose of this study is to address the issue of age in the effects of maltreatment. The following discussion is divided into preschool, school age and adolescent groups in reviewing the literature on maltreatment effects on these age groups.

Maltreatment Effects on Preschool-Aged Children

Preschool children are at risk for serious disabilities due to child abuse. (See Chapter 1, p. 5). Ewing-Cobbs and others (1998) found 45% of children surviving brain injury resulting from violence to be mentally retarded compared to only 5% of those surviving accidental injury. DiScala, Sege, Li, and Reece (2000) reported almost 11% of all brain injury to children five years old and under resulted from battery, shaking, and other forms of violence. Shaken Baby Syndrome or Shaken Impact Syndrome, a vigourous manual shaking of an infant who is being held under the arms or by the shoulders, can result in the child's brain moving within the skull, causing blood vessels to stretch and tear with no obvious external signs of injury and may cause death, permanent brain damage, or long-term disability (David, 1999; Miller-Perrin & Perrin, 1999). In fact, about 60% of infants who survive Shaken Baby Syndrome will have severe disabilities and most of the remaining survivors will have milder disabilities (Lund, Sandgren, & Knudsen, 1998).

Women who use alcohol or illicit substances during pregnancy place their unborn infants at risk for disabilities. The effects of alcohol and other drugs can

directly cause problems for the fetus, such as prematurity, low birth weight, small head size, oxygen deprivation, brain hemorrhaging, congenital heart defects, and learning problems (Jaudes & Shapiro, 1999).

Researchers also have found that maltreated preschoolers are likely to show developmental delay (White, Halpin, Strom, & Santilli, 1988), delayed motor development (Lyons-Ruth, Connell, & Zoll, 1989), delayed language skills (Allen & Oliver, 1982; Culp et al., 1991), and diminished intellectual functioning and academic achievement (Erickson, Egeland, & Pianta, 1989; Vondra, Barnett, & Cicchetti, 1990). As previously discussed, child maltreatment can cause disabilities. According to Mullins' review (1986), studies also show that disabilities of some children who were originally diagnosed with disabilities are exacerbated by maltreatment. While cause and effect are not easily determined in some cases, researchers agree that there is a relationship between disability and maltreatment (Mullins, 1986).

Compared to non-maltreated preschoolers, maltreated preschool children showed symptoms of depression, social withdrawal or anxiety disorders, and inappropriate sexual behavior (Mian, Marton, & LeBaron, 1996). Kashani and Carlson (1987) also found that all clinically depressed preschoolers in their sample were maltreated by a parent. Depressive symptoms of this age group, including sadness, appetite loss, sleep changes, fatigue, and somatic complaints, distinguished depressed preschoolers from

psychiatric preschoolers. Maltreated preschoolers also tend to be more withdrawn and aggressive with peers (Haskett & Kistner, 1991; Klimes-Dougan & Kistner, 1990), and more aggressive with siblings (Crittenden, 1992) than non-maltreated children.

Maltreatment Effects on School-Aged Children

The effects of maltreatment appears to continue into the school-age years. An examination of maltreated and non-maltreated 5-to-10 year-olds revealed a significant incidence of psychiatric disorder diagnoses among maltreated children. These disorders included attention-deficit hyperactivity disorder, oppositional defiant disorder, post-traumatic stress disorder, personality, adjustment, mood, and conduct disorder diagnoses. Compared to a control group, maltreated children were found to have a significant incidence of psychotic symptomatology (9.3% vs. 0%; Famularo, Kinscherff, & Fenton, 1992). In other research, maltreated children of school age scored significantly higher on self-report measures of depression than non-maltreated children (Allen & Tarnowski, 1989; Kazdin, Moser, Colbus, & Bell, 1985).

Researchers also found difficulties in behavior among maltreated school-aged children including withdrawal and sexual behavior problems (Hibbard & Hartman, 1992; Kaufman & Cicchetti, 1989), aggressive behavior (Salzinger, Feldman, Hammer, & Rosario, 1993; Sheilds & Cicchetti, 1998), and drug use (Kolko, Moser, & Weldy, 1990).

Developmental, physical, and cognitive signs of

maltreatment in maltreated children also have been found. Compared to non-maltreated counterparts, maltreated school-aged children exhibited more early developmental delays, chronic health problems, neurologic soft signs, serious physical injuries, skin marks, and scars (Kolko et al., 1990). Maltreated children also had significantly lower cognitive maturity scores as measured by standardized verbal comprehension and school competence tests than non-maltreated children (Trickett, 1993).

Maltreatment Effects on Adolescents

Maltreated adolescents appear to have a combination of many effects. Compared to non-abused adolescents, abused adolescents showed significant impaired functioning including more depressive symptoms, anxiety, psychiatric disorders, emotional-behavioral problems, suicidal ideation and suicide attempts (Pelcovitz, Kaplan, DeRosa, Mandel, & Salzinger, 2000; Silverman, Reinherz, & Giaconia, 1996).

In addition to suicidal tendencies, other risk-taking behaviors have been found among maltreated adolescents. They were three times more likely than non-maltreated peers to drink alcohol and smoke cigarettes, almost twice as likely to use illicit drugs, and had 3.5 times greater chance of being sexually active (Riggs, Alario, & McHorney, 1990). Generally, maltreated adolescents had a higher incidence of acting-out behavior, running away, legal involvement, and sexual promiscuity (Cavaiola & Schiff, 1988). Other behavior problems include antisocial behavior (Bensley, Van Eeenwyk, Spieker, & Schoder, 1999), and

abusive and victimization behaviors in dating relationships (Wolfe, Wekerle, Reitzel-Jaffe, & Lefebvre, 1998).

Study Rationale and Hypotheses

Although studies show that children of different ages are at risk for a variety of mental health, emotional, cognitive, and behavioral issues, the generalizability of these studies is limited. Many of these studies used non-representative samples, lacked appropriate groups for comparison, had small sample sizes, used unstandardized or different measures of maltreatment effects, overlapped the age groups, or have different ranges for specific age groups. As a result, knowledge on the effects of maltreatment on specific age groups is limited.

Therefore, in order to understand age effects of maltreatment, this study aims to improve on previous methodological limitations by (a) using a large nationally representative sample of children and adolescents reported for maltreatment to child welfare agencies, including a comparison group, (b) using a list of several clinical findings that are consistent with those examined in the literature, and (c) using specific age levels of approximate equal frequency and span (e.g., four year intervals).

Because children at different age levels likely show different effects of maltreatment, it is important for professionals within the field of child maltreatment to understand these effects. Such an understanding can lead professionals' efforts to appropriately meet children's and

adolescents' specific needs through assessment, prevention, and intervention. Furthermore, understanding effects of maltreatment across age levels can increase these professionals' awareness of different signs of maltreatment, differentiate normal development and maltreatment effects, and guide their decisions for reporting maltreatment.

The general purpose of this study is to identify and describe the proportions of children and adolescents identified for a variety of clinical findings and disabilities. The two hypotheses to be tested in this study are as follows: (a) There will be no differences in the proportions of children and adolescents identified for various clinical findings across age levels; (b) There will be no differences in the proportions of children and adolescents identified for various disabilities across age levels.

Method

Data Collection

The data used in this study were collected as part of the Canadian Incidence Study of Reported Child Abuse and Neglect (CIS), Canada's first national study which examines the incidence of reported child abuse and neglect and the characteristics of children and their families investigated by Canadian child welfare services. This nationally representative sample of children investigated for suspected maltreatment was collected using a four-stage stratified sampling design. (See Chapter 1, pp. 10-13 for a

brief description of the sampling design and data collection procedures.) A full description is available in Trocme et al. (2001).

The present study included substantiated, suspected, and unsubstantiated child welfare investigations. It did not include reports that were screened out before a full investigation, cases that were investigated only by police, new incidents of maltreatment on open cases at time of data collection, and incidents that were not reported to child welfare services (Trocme et al., 2001).

This study utilized information from the Intake Face Sheet and a component of the Child Information Sheet, the Child Functioning Checklist. This checklist was developed in consultation with child welfare workers and researchers as an index of the types of issues (physical, emotional, cognitive, and behavioral) likely identified in child maltreatment investigations. Because the checklist items included only issues that child welfare workers became aware of during investigations, the original researchers believed that a more systematic assessment of issues would likely lead to identification of more issues than identified by workers during the study. Thus, the occurrence of issues is likely underestimated. However, it provides a first and important estimate of the types of issues identified during child maltreatment investigations (Trocme et al., 2001).

In using this checklist, investigating workers were asked to indicate problems that had been confirmed by a

disclosure, formal diagnosis or direct observation as well as issues that they suspected were problems, but could be confirmed at the time of investigation. For this study, the categories for confirmed and suspected were collapsed as "identified" because the distinction between confirmed and suspected was not documented in all jurisdictions (Trocme et al., 2001). Furthermore, clinical findings in this study are listed as behavioral, physical, emotional and cognitive health issues in the CIS. The types of disabilities described in this study are categorized as physical, emotional, and cognitive health issues in the CIS.

Participants

The participants of this study included 7633 children aged 0 to 15 years. These data include only up to age 15 to remain consistent with the application of the varied definitions of "child" across jurisdictions. The mean age of the whole sample is 7.5 years (SD=4.48). The analysis also involved the original age categories in the dataset, including 0 to 3 years (n=1764; 23.1%), 4 to 7 years (n= 2140; 28%), 8 to 11 years (n=1876; 24.6%) and 12 to 15 years (n=1853; 24.3%).

Results

Due to the categorical nature of the data, a series of chi-square analyses were conducted. Table 3-1 describes the proportions of children and adolescents identified for a variety of clinical findings at four age levels and the total sample. These results test the hypothesis that there will be no differences in the proportions of children and

adolescents identified for various clinical findings across age levels. Table 3-2 describes the proportions of children and adolescents identified for a variety of disabilities at four age levels and the total sample. The results in this table test the hypothesis that there will be no differences in the proportions of children and adolescents identified for various disabilities across age levels. The average number of clinical findings that a child is likely to have was also calculated.

Children with Identified Clinical Findings

Table 3-1 reports the percentages of children at each age level and in the sample who were identified as having various clinical findings.

Table 3-1

Percentages of Children at Age Levels and Total Children in Sample with Identified Clinical Findings

Clinical Finding	Age Level				Total
	0-3	4-7	8-11	12-15	
Behavior Problem	4.4	16.1	25.9	39.7***	21.6
Depression or Anxiety	1.5	4.7	10.0	18.5***	8.6
Irregular School Attendance	0.1	2.9	4.6	19.2***	6.6
Negative Peer Involvement	0.2	2.3	6.6	16.9***	6.4
Violence to Others	0.9	2.8	6.4	9.9***	5.0
Running Away	0.4	0.3	1.5	13.0***	3.7
Once	(0.2)	(0.0)	(0.7)	(6.1)***	(1.7)
Multiple	(0.3)	(0.2)	(0.9)	(7.6)***	(2.2)
Substance Abuse	0.2	0.2	0.9	12.2***	3.3
Age Inappropriate Sexual Behavior	0.6	3.0	1.8	5.2***	2.7
Self-Harming Behavior	0.3	0.6	2.2	7.2***	2.5
Psychiatric Disorder	0.2	1.0	2.4	3.9***	1.9
One or More	7.0	23.8	36.2	59.6***	31.7

Note. Column percentages do not add up to percentage in the One or More column because children were identified in more than one category.

***p<.001 (See text, pp. 98-99 for X^2 values.)

Children of all ages

As shown, behavior problem was the most common clinical finding (21.6%) identified in the whole sample (n=7633). It was more than twice the percentage of depression or anxiety (8.6%). Irregular school attendance (6.6%), negative peer involvement (6.4%), and violence to others (5%) were also among the five most common clinical findings. Running away, substance abuse, age inappropriate sexual behavior, self-harming behavior, and psychiatric disorder were each identified at less than five percent of the total sample. Although child welfare workers were required to document other specific concerns not listed on the Child Functioning Checklist, these types of concerns were only categorized as "other" in the CIS data. This "other" category did not specify those concerns and it was not included in the data analysis.

Specific age levels

Also shown in Table 3-1, each age level varies in the frequency of clinical findings. For age level 0 to 3 years, behavior problem was again the most frequently identified clinical finding at over four percent, and depression or anxiety was the second most common at 1.5 percent. Violence to others and age-inappropriate sexual behavior were the next most common clinical findings at almost one percent each. The remaining clinical findings listed were each identified at less than one percent.

The 4 to 7 year age level also showed behavior problem (16.1%) and depression or anxiety (4.7%) as the two most

frequent clinical findings. Behavior problem was over three times the percentage of depression or anxiety. Negative peer involvement, violence to others, irregular school attendance, and age inappropriate sexual behavior range from 2.3% to 3%. Psychiatric disorders, self-harming behavior, running away, and substance abuse were the least frequently identified clinical findings (one percent or less).

The age level 8 to 11 years showed that behavior problem was more than twice the percentage of depression or anxiety (25.9% vs. 10%). Similar percentages (over 6% each) of these children were identified for negative peer involvement and violence to others. Over four percent of 8 to 11 year-olds were identified for irregular school attendance. Self-harming behavior and psychiatric disorder were similar in frequency with each being slightly over 2%. Age inappropriate sexual behavior, running away, and substance abuse were the least common clinical findings for this age level.

Finally, the 12 to 15 year age level has the highest percentages of each clinical finding. Behavior problem was the most common clinical finding at almost 40 percent. Irregular school attendance was the second most common clinical finding (more than 19%) followed by depression or anxiety (18.5%). Negative peer involvement was identified at about 17 percent. Running away (13%) and substance abuse (over 12%) were also common for this age level. Almost 10 percent of 12 to 15 year-olds were identified for violence

to others. Self-harming behavior (7.2%), age inappropriate sexual behavior (5.2%), and psychiatric disorder (3.9%) were the least common clinical findings. Overall, these percentages were higher than for any other age level.

One or more clinical findings

Table 3-1 also displays the percentage of children who are likely to have one or more clinical findings. Almost 32 percent of the whole sample was identified for at least one clinical finding. Seven percent of children in the age level 0 to 3 years had at least one clinical finding. The other age levels ranged from almost 24 percent to almost 60 percent.

Significant differences in chi-square values

Chi-square analyses found significant differences among age levels for the following: behavior problem, $X^2(3, N=7633) = 726.284$, $p<.001$, depression or anxiety, $X^2(3, N=7633) = 388.126$, $p<.001$, irregular school attendance, $X^2(3, N=7633) = 656.838$, $p<.001$, negative peer involvement, $X^2(3, N=7633) = 517.305$, $p<.001$, violence to others, $X^2(3, N=7633) = 188.756$, $p<.001$, running away (once or multiple times), $X^2(3, N=7633) = 601.136$, $p<.001$, running away (once), $X^2(3, N=7633) = 285.079$, $p<.001$, running away (multiple times), $X^2(3, N=7633) = 338.208$, $p<.001$, substance abuse, $X^2(3, N=7633) = 612.568$, $p<.001$, age inappropriate sexual behavior, $X^2(3, N=7633) = 80.138$, $p<.001$, self-harming behavior, $X^2(3, N=7633) = 232.337$, $p<.001$, and psychiatric disorder, $X^2(3, N=7633) = 79.448$, $p<.001$.

Chi square analyses also revealed a significant relationship among age levels for one or more clinical findings, $X^2(3, N=7633) = 1244.198$, $p<.001$.

Generally, it was found that the percentages increased as age increased. For each of these clinical findings, the highest percentage was found at the 12 to 15 years age level. In most cases, the percentages in the 12 to 15 year level were much greater than the younger age levels. The 12 to 15 age level appeared to have the largest difference for each clinical finding and the one or more category.

Average number of clinical findings

Average number of clinical findings that a child is likely to have also has been calculated. Overall, children at age levels 0 to 3, 4 to 7, and 8 to 11 years have a likelihood of having about one clinical finding (1.33, 1.43, 1.76 respectively). Children aged 12 to 15 years are likely to have more than two clinical findings (2.67) compared to 2.08 issues for the total sample. Regardless of statistical probability, the difference would not be expected to have any clinical significance.

Children with Disabilities

Table 3-2 shows the percentages of children at each age level and in the sample who were identified as having various disabilities.

Table 3-2

Percentages of Children at Age Levels and Total Children in Sample with Identified Disabilities

Disability	Age Level				Total
	0-3	4-7	8-11	12-15	
Developmental Delay	8.9	9.9	8.1	7.6	8.7
Other Health Conditions	6.2	3.3	3.1	3.6 ***	4.0
Physical or Developmental Disability	4.3	3.7	3.3	2.5 *	3.4
Substance Abuse Related Birth Defects	2.2	2.1	1.4	2.1	1.9
One or More	16.0	14.4	13.0	12.2 **	13.9

Note. Column percentages do not add up to percentage in the One or More column because children were identified in more than one category.

*p<.05 **p<.01 ***p<.001 (See text, pp. 102 for X^2 values.)

Children of all ages

Developmental delay was the most common disability (8.7%) identified in the whole sample (n=7633). It was more than twice the percentage of other health conditions (4%) which includes ongoing health conditions, such as chronic or frequent hospitalizations. Physical or developmental disability, including autism, paralysis, cerebral palsy, or learning disability, was the third most identified

disability (3.4%). Substance abuse-related birth defects, such as Fetal Alcohol Syndrome or Fetal Alcohol Effect, cocaine addiction, or solvent use by biological mother, was identified for about two percent of the total sample of children.

Specific age levels

Also shown in Table 3-2, a similar pattern of descending frequency of disabilities appears at each age level.

At age level 0 to 3 years, developmental delay was again the most frequently identified disability at almost 9 percent, followed by other health conditions at 6.2 percent, physical developmental disability at 4.3 percent, and lastly, substance abuse-related birth defects at 2.2 percent.

For children aged 4 to 7 years, developmental delay was three times more commonly identified compared to other health conditions (9.9% and 3.3%). Physical or developmental disability was the second most commonly identified (3.7%) at this age level whereas other health conditions were the third most frequent. Birth defects by substance abuse were the least common disability.

The age level 8 to 11 years also showed that developmental delay was the most common disability (over 8%). Physical or developmental disability and other health conditions were each at slightly over three percent and 1.4 percent of all 8 to 11 year-olds were identified for substance abuse-related birth defects.

Finally, the 12 to 15 year age level shows that developmental delay is more than twice the percentage of other health conditions (7.6% and 3.6%). Physical or developmental disability and substance abuse-related birth defects were each identified at over two percent.

One or more disabilities

Table 3-2 also displays the percentage of children likely to have one or more disabilities. Almost 14 percent of the whole sample was identified for at least one disability. Sixteen percent of the 0 to 3 year-olds were identified for at least one disability. The other age levels ranged from 12.2 to 14.4 percent.

Significant differences in chi-square values

Chi-square analyses found significant differences among age levels for other health conditions, $X^2(3, N = 7633) = 31.005$, $p<.001$. Analysis also revealed significant differences among age levels for physical or developmental disability, $X^2(3, N = 7633) = 8.813$, $p<.05$. Chi-square analyses found a significant relationship between age groups and having at least one disability, $X^2(3, N = 7633) = 12.844$, $p<.01$.

Overall, it was found that the percentages decreased as age increased. The highest percentages were found at the 0 to 3 year age level for other health conditions, physical or developmental disability, substance abuse-related birth defects, and having at least one disability. The age level 4 to 7 years had the highest percentage for developmental delay.

There were cases in which the highest percentages also appeared to have the largest differences. For example, the 0 to 3 age level appeared to have the largest difference for other health conditions and at least one disability. Also, the 4 to 7 age level appeared to have the largest difference for developmental delay. In some cases, such as physical or developmental disability and substance abuse-related birth defects, the lowest percentages appeared to have the largest differences.

Discussion

The general purpose of this study was to examine the proportions of children and adolescents reported for maltreatment, who were identified for behavioral, social, mental, and emotional clinical findings and disabilities. Overall, the results show that behavior problem was overwhelmingly the most common clinical finding and developmental delay was the most common disability for the total sample and all age levels. The least common clinical finding was psychiatric disorder for the total sample and it was among the least common for all age levels. The least common disability was substance abuse-related birth defects for the sample and all age levels.

This study also found significant relationships among age groups and each clinical finding. A significant relationship was also found among age levels and having at least one clinical finding. Generally, the percentages of children identified for each clinical finding had increased as age increased; the percentages of children identified

for at least one clinical finding also increased as age increased. Therefore, these findings did not support the first hypothesis, i.e., that there will be no differences in proportions of children and adolescents identified for various clinical findings across age levels.

There was a significant relationship among age levels and other health conditions. The relationship among age levels and physical or developmental disability was also significant. A significant relationship among age levels and having at least one disability was found. In general, the percentages of children identified for each disability had decreased as age increased; the percentages of children identified for at least one disability had decreased as age increased. Thus, these results did not support the second hypothesis, i.e., that there will be no differences in proportions of children and adolescents identified for various disabilities across age levels. The following is a summary of findings for each age level.

Children aged 0 to 3 years had the lowest proportions for each clinical finding. Seven percent of children aged 0 to 3 years were identified for at least one clinical finding, which the lowest percentage among all age levels. Age level 0 to 3 had an average about one clinical finding (1.33). However, age level 0 to 3 years had the highest proportions for other health conditions (6.2%), physical or developmental disability (4.3%), an substance abuse-related birth defects (2.2%). Children aged 0 to 3 years also had the highest proportion (16%) identified for at least one

disability. The 0 to 3 age level appeared to have the largest difference for other health conditions and having at least one disability.

In general, the percentages of children aged 4 to 7 years were greater than percentages of children aged 0 to 3 years for each clinical finding. Almost 24% of children aged 4 to 7 years were identified for at least one clinical finding. Regarding disabilities, children in age level 4 to 7 had the highest proportion for developmental delay (9.9%). Over 14% of children aged 4 to 7 were identified for at least one disability, which is lower than the proportion for age level 0 to 3 years (16%). The 4 to 7 age level appeared to have the largest difference for developmental delay.

For every clinical finding, the percentages of children in age level 8 to 11 were higher than the percentages of children in 4 to 7 age level. One exception was age inappropriate sexual behavior, which was more common among 4 to 7 years-olds (3%) than 8 to 11 year-olds (1.8%). This finding of age inappropriate behavior among 4 to 7 year-olds is consistent with other results from previously reviewed research examining children aged 4 to 8 years (e.g., Hibbard & Hartman, 1992). Furthermore, this finding of age inappropriate sexual behavior in children aged 4 to 7 is consistent with Finkelhor and Browne's (1985) traumatic sexualization and likely reflects sexual behavior that is considered inappropriate in younger children yet tolerated in older children. For each

disability, the proportions of children in age level 8 to 11 were lower than proportions of children in age level 4 to 7. Compared to 14.4% of children aged 4 to 7 years who were identified for at least one disability, 13% of children aged 8 to 11 years were identified for at least one disability. The 8 to 11 age level appeared to have the largest difference for substance abuse-related birth defects.

Compared to the younger age levels, age level 12 to 15 years had the highest percentages for all clinical findings. Almost 60% in age level 12 to 15 were identified for at least one clinical finding. Children aged 12 to 15 had the highest average number of issues (2.67). The 12 to 15 age level appeared to have the largest difference for each clinical finding and the one or more category. Regarding disabilities, children aged 12 to 15 years had the lowest proportion (12.2%) identified for at least one disability. The 12 to 15 age level appeared to have the largest difference for physical or developmental disability.

The general patterns of an increase in percentages across age levels for clinical findings and a decrease in percentages across age levels for disabilities appears to reflect age effects. Therefore, implications for assessment, prevention, and intervention may vary for each age level. The following paragraphs discuss these implications.

Because children aged 0 to 3 years have less

sophisticated communication skills to communicate any maltreatment experiences, it is likely that their difficulties will go undetected. It was found in this study that behavior problem, depression or anxiety, age inappropriate sexual behavior, and violence to others were the most common clinical findings among 0 to 3 year-olds. Other researchers have found similar results in nonrepresentative samples of preschool maltreated children (Crittenden, 1992; Haskett & Kistner, 1991; Kashani & Carlson, 1987; Mian et al., 1996). These results indicate that assessment of 0 to 3 year-olds may involve detection of signs of depression, such as somatic complaints, sleep disturbance, or loss of appetite, and behavior indications, including age inappropriate sexual behavior and violence to others. Also, day care workers, social workers, and other professionals who work with this young population need to assess for physical signs of maltreatment such as unusual bruising, burns, scars, tears, and so forth (Miller-Perrin & Perrin, 1999). Although the proportions of 0 to 3 year-olds were the lowest for all clinical findings in this study, these results suggest that 0 to 3 year-olds are at risk of experiencing various clinical findings.

The 0 to 3 age level's lack of exhibition of clinical findings could also be explained in that they may not show the full effects of maltreatment until later (Beitchman, Zucker, Hood, daCosta, & Akman, 1991). In addition, 0 to 3 year-olds do not have the opportunity to engage in some behaviors as would older children and adolescents.

Prevention, such as family focused programs, is an important step in helping these young children. Prevention can involve using community resources for high risk-families, teaching parents about maltreatment, child development, and providing services available to parents, such as home visits, volunteers, parent groups, and parent training courses (Gough, 1988).

The results of this study show that children aged 0 to 3 years were more likely to have a disability than older children and adolescents, particularly developmental delay and other health conditions. It is difficult to know if these disabilities are a cause or effect of maltreatment (Ammerman et al., 1986), unless there are some obvious signs of physical trauma (e.g., Reece, 1994). Disabilities at this young age can increase the children's risk for initial or ongoing maltreatment. Prevention or early intervention needs to involve extra supervision of children with disabilities at risk for maltreatment. Extra supervision is important to protect these children at risk and to observe interactions between parents and children in order to help parents and their children more effectively (Oates, 1996).

Home services and therapeutic day care are other options for helping children aged 0 to 3 who are identified for various clinical findings and disabilities. Home services of skilled social workers, nurses, or developmental specialists can work with parents and the child together (Kempe, 1997). Therapeutic day care programs

with coordinated individual therapy for parents or family therapy are another option (Kempe, 1997; Oates, 1996). This kind of program provides therapeutic day care for children and involves working with the parents to help them with anger management, teach them how to respond to their children's behavior, and improve their self-concept (Oates, 1996).

In this study, the most common clinical findings among children in age levels 4 to 7 and 8 to 11 years were behavior problem, depression or anxiety, irregular school attendance and impaired peer relations, such as negative peer involvement and violence to others. Other researchers found similar results in nonrepresentative samples of maltreated school-aged children (Allen & Tarnowski, 1989; Famularo et al., 1992; Salzinger et al., 1993). All of these clinical findings require assessment and treatment to meet school-aged children's needs.

Children aged 4 to 7 and 8 to 11 in this study need to be assessed for cognitive disability or learning problems, which may explain the high percentages of behavior problems and irregular school attendance. Such assessment is particularly important during school-age years in order to prevent behavior problems and irregular school attendance in adolescence. Also, depression or anxiety among school-aged children in this study requires assessment and treatment.

To address negative peer involvement and violence to others found in school-aged children, group therapy may

assist these children in their improvement of peer relations, verbalization and sharing of feelings, and socialization and limit-setting. This treatment modality may also help school-aged children with anxiety and behavioral symptoms (Kempe, 1997). Play or art therapy could be another alternative to help these children communicate their feelings. Individual therapy for school-aged children may also be appropriate in conjunction with group therapy or family therapy. School-aged children with serious behavior problems or psychopathology may require more intensive therapy (Kempe, 1997).

In this study, developmental delay was the most common disability among children aged 4 to 7 and 8 to 11 years. Substance abuse-related birth defects was found to have the largest difference among 8 to 11 year-olds. These results suggest the need to assess school-aged children for these disabilities. Such assessment may aid the development of appropriate ongoing treatment and educational plans for these school-aged children with disabilities.

The results of this study show that adolescents aged 12 to 15 years had the highest proportions for all clinical findings. One explanation is that these older children have been subjected to maltreatment longer than younger children, the effects are cumulative, and they emerge in these later years (Beitchman et al., 1986). Consequently, adolescents have a variety of assessment and intervention concerns.

This study found that depression, anxiety, and

substance abuse were common clinical findings among children aged 12 to 15 years. Other researchers from similar results in nonrepresentative samples of adolescents (Pelcovitz et al., 2000; Riggs et al., 1990). Also, in this study, psychiatric disorders was among the least frequent clinical findings identified for age level 12 to 15. However, the proportion of 12 to 15 year-olds identified for psychiatric disorders was higher than the younger age levels. Comprehensive assessment also could involve screening for depression, anxiety, substance abuse, and psychopathology. Treatment for these depression, anxiety, substance abuse, and psychiatric disorders may involve medications, therapy and/or addiction recovery programs for adolescents aged 12 to 15 years.

Because behavior problems, negative peer involvement, and violence to others were frequently identified in this study, adolescents need to learn conflict resolution skills. Treatment may involve residential programs, group counselling, or individual therapy to specifically meet the adolescents' needs (Kempe, 1997).

This study found that running away was another common clinical finding among the 12 to 15 age level. Researchers have found that runaway adolescents are at increased risk of further violence (Janus, Archambault, Brown, & Welsh, 1995) and more likely to engage in suicidal behavior (Levine Powers, Eckenrode, & Jaklitsch, 1990). Self-harming behavior was found in over 7% of those aged 12 to 15 in this study. As with the other clinical findings, it is

important to view running away and suicidal tendencies as coping mechanisms. Although self-harming behavior was defined as high-risk or life-threatening behavior, suicide attempts or physical mutilation or cutting in this study (Trocme et al., 2001), it is important to note that self-harming behavior may or may not indicate suicidal tendencies. Therefore, assessment and treatment of these behaviors among adolescents need to address intentional and nonintentional behaviors. Adolescents also need to be given alternatives to these behaviors as well as life skills training.

Overall, the results of this study emphasize the need for early and ongoing assessment for various clinical findings and disabilities across all age levels. Assessment could be implemented at regular intervals and with a variety of assessment measurements, such as behavioral observations, parent and/or teacher ratings for preschool-aged children, and self-report for older children and adolescents (Kravic, 1987). Such assessment could help determine risk for certain clinical findings and develop appropriate strategies to prevent or intervene early at each age level. Assessing for disabilities at each age level could also aid in the development of appropriate strategies to meet children's needs.

The findings of this study may help professionals, such as frontline child and youth workers, day care workers, and teachers, to be aware of the risk of the different types of clinical findings at different age

levels. Awareness of these clinical findings at different ages may help professionals who work with children understand differences between developmentally normal behavior and effects of maltreatment. Understanding these differences may give professionals a clearer sense of how to recognize or suspect child maltreatment. This would be beneficial for the purposes of reporting suspected cases of child maltreatment to child welfare authorities.

It is important to point out that when professionals are considering to report maltreatment, they need to be aware of conditions that mimic child maltreatment (e.g. Bays, 1994a; Bays, 1994b; Zinn, 1994). Furthermore, the use of checklists to determine characteristics that may put a child at risk for maltreatment may be beneficial in monitoring a child for possible maltreatment (Browne & Saqi, 1988).

A few limitations of this study need to be considered. First, the effects of maltreatment are not certain in this sample because the design of the study does not allow for conclusions regarding cause and effect. Second, clinical findings and disabilities were only identified by social workers. However, their knowledge of clinical findings and disabilities was based on extensive training, and confirmed concerns were on the basis of specific criteria. Third, the proportions of 0 to 3 years-olds identified for various clinical findings were not zero as one might expect. Irregular school attendance (0.1%), running away (0.4%), substance abuse (0.2%), depression or anxiety (1.5%) are

some examples. Because most of these clinical findings are not clearly defined in the CIS, it is unknown how the social workers interpreted these items on the checklist when collecting data. Lastly, because many modern statistical authorities argue against using a prespecified probability level for testing (Shadish, Cook, & Campbell, 2002), no specific criterion level was used to judge statistical significance. It is also important to point out that in each of the two tables, there are multiple tests. This suggests a need for a conservative standard in evaluating the probability levels of individual variables. Probabilities found to be less than .001 suggest that they are extremely unlikely to have occurred as a result of chance, regardless of the multiple comparisons. Results with probability levels of greater than .01 should be viewed with caution.

Conclusion

These results suggest a myriad of clinical findings and disabilities are present in a nationally representative group of children and adolescents reported for maltreatment. In general, the percentages of children identified for clinical findings increased across age levels, whereas the percentages of children identified for disabilities decreased across age levels. The findings of this study lend to a developmental framework to guide assessment, prevention, intervention, and decisions for reporting child and adolescent maltreatment.

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CHAPTER 4

Similarities and Differences between Children with and without Disabilities on Identified Clinical Findings

Introduction

Many reviews document the detrimental effects of maltreatment on nondisabled children's and adolescents' mental, emotional, social, and physical development and health (e.g., Browne & Finkelhor, 1986; Cahill, Kaminer & Johnson, 1999; Green, 1993; Hildyard & Wolfe, 2002; Kaplan, Pelcovitz, & LaBruna, 1999; Kendall-Tackett, Williams, & Finkelhor, 1993; Trickett & McBride-Chang, 1995). Effects summarized include anxiety, fear, phobias, post-traumatic stress disorder, depression, suicidal tendencies, anger, hostility, conduct disorders, psychiatric symptoms and disorders, increased aggression, physical symptoms, somatic complaints, inappropriate sexual behavior, substance abuse, academic and disciplinary problems, truancy, and running away from home. Other researchers have examined maltreatment effects among people with disabilities (e.g., Westcott, 1993); however, methodological shortcomings including clinical, unrepresentative, and small samples, inappropriate control groups for comparison, and lack of consistent or standard measures of effects limit the generalizability of these findings to children with disabilities. Thus, the general purpose of this study is to address the role of disability status in the presence of various behavioral, cognitive, mental, and emotional effects of maltreatment in a large, representative sample.

Compared to literature on the effects of maltreatment among people without disabilities, the effects of

maltreatment among adults, children, and adolescents with disabilities have been examined to a much lesser extent. Most published research in the area has examined effects of sexual abuse on adults or children with developmental disabilities. Cole's review (1986) summarized similar sexual abuse effects for persons with and without disabilities, including shame, guilt, loss of self-esteem, fear of abandonment, learning problems, and delinquent behavior. Cruz, Price-Williams, and Andron (1988) found, in their qualitative study, that feelings expressed by adult counselling clients with developmental disabilities, such as isolation, anger, alienation, depression, low self-esteem, and fear of abandonment, and behaviors such as sexually age inappropriate, self-abusive or suicidal behavior, were similar to effects noted in sexual abuse effects literature. A survey of sexual abuse victims with mild/moderate and severe/profound developmental disabilities found reports of withdrawal (9.8% and 17.7% respectively), aggressive behavior and/or other behavior problems, such as inappropriate sexual behavior (19.6% and 31.1%), and unspecified emotional distress (56.8% and 35.5%). Only a small percentage (slightly less than 4% of those with mild or moderate disabilities and none of those with severe or profound disabilities) reported no emotional or social problems. Differences between mild to moderate and severe to profound disabilities were not significant (Mansell, Sobsey, & Calder, 1992).

Recently, Balogh and others (2001) found verbal and physical aggression, self-harm, sexualized behaviors, and anxiety in a child and adolescent psychiatric group of intellectually disabled who were sexually abused. Finally, in their clinic sample of sexually abused children and adolescents, Mansell, Sobsey and Moskal (1998) found no differences in the presentation of clinical findings between children with and without disabilities, except on poor sense of personal safety, little or no age appropriate sexual knowledge, and personal hygiene among children with disabilities. Generally, these researchers have found no evidence to support the hypothesis that individuals with developmental disabilities experience different sexual abuse sequelae than those without disabilities.

In other research, some responses of people with developmental disabilities appear to be qualitatively different or intensified from those without disabilities. For instance, Varley (1984) and Martorana (1985) discussed case studies of adolescents with developmental disabilities who developed schizophrenic psychotic symptoms after experiencing sexual assault. Varley suggested the possibility that sexual assault can contribute to psychotic symptoms and those with developmental disabilities exhibit greater vulnerability to psychiatric disturbances, which may produce a qualitatively different response. Furthermore, the effects may be more devastating for persons with developmental disabilities because of coping

with difficulties and additional vulnerability to abuse such as dependency and limited communication and social skills (Tharinger, Horton, & Millea, 1990).

Greater behavioral difficulties have been noted by some researchers examining sexual abuse effects among individuals with developmental disabilities. Dunne and Power (1990) found clinicians reported behavior problems such as "acting out" behavior, verbal abuse, and inappropriate sexual behavior in working with persons with mental disabilities, as possible indicators of sexual abuse. They also identified increased anxiety, distress and fearfulness, greater vulnerability to revictimization, increased restrictiveness on personal freedom, and long-term depression in their sample. Burke and Bedard (1995) found that 54% of adults with developmental disabilities referred for treatment of self-injury behavior were victims of sexual abuse. Given the lack of communication skills of disabled persons, these behavior problems have been explained as ways to communicate abuse experiences (Dunne & Power, 1990).

Trauma may exacerbate physical and cognitive disabilities. For instance, sexual assault can magnify speech problems which impede a victim's ability to communicate. A person with spinal cord injury may be physically powerless and such helplessness is magnified by the assault. In addition, those with developmental or learning disabilities may be more confused, have more

problems with concentration and organizing their thoughts, and have greater difficulty understanding their sexual abuse than those without such disabilities (Bowers Andrews, & Veronen, 1993; Stuart & Stuart, 1981).

Similar results to previously reviewed studies were found by other researchers who have examined multiple or different forms of maltreatment or other disabilities. Cook, Kieffer, Charak, and Leventhal (1993) described a case study of an adolescent autistic boy who was diagnosed with post traumatic stress disorder after being physically abused by a staff member at a residential school. Howlin and Clements (1995) found that when maltreatment was occurring at a residential school, autistic children showed increased aggressive, self-injurious behaviors, mood swings, temper tantrums, fears or resistance to being separated from parents and going to school, increased activity levels, sleeping disturbances, and eating problems. These behaviors decreased after they were removed from the school. No changes in autism-specific symptoms such as obsessive or stereotypical behaviors were noted. It was concluded that the consistency in the types of behavioral difficulties and the timing of the rise in behavioral disturbance suggests children's marked emotional distress following their experiences at school (Howlin & Clements, 1995). Maltreated children with intellectual disabilities showed stereotyped behavior or eating problems (67%), difficult temperament (64%), and self-injury (63%),

compared to non-maltreated children with disabilities who showed eating problems (19%), difficult behavior (13%), and self-injury (4%) (Verdugo, Bermejo, & Fuertes, 1995). Walters, Barrett, Knapp, and Borden (1995) found in a psychiatric sample of suicidal youth with mental retardation, 10.5% had been physically abused, 10.5% were sexually abused, and 26% were both physically and sexually abused. Westcott's (1993) qualitative study found that effects of all types of abuse described by adults with and without physical and cognitive disabilities were congruent with effects of sexual abuse discussed in the literature. Thus, effects of different types of maltreatment among those with different types of disabilities appear similar to effects experienced by those without disabilities.

Using representative samples, Sullivan and Knutson (2000a) found that maltreated children with disabilities had the lowest school attendance and academic achievement scores. In another study, maltreated disabled runaways scored significantly lower on academic achievement tests and had significantly lower school attendance compared to maltreated nondisabled runaways (Sullivan & Knutson, 2000b). Furthermore, Sullivan and Knutson (2000b) also found that the risk of running away, for children with disabilities, was approximately five times that of children without disabilities in a general school population. Similarly, children with disabilities were six times more likely to run away from home than children without

disabilities in a hospital sample. In addition, the prevalence rate of a diagnosed disability among maltreated runaways was about 83% compared to 47% among non-maltreated runaways. Although these studies used larger and representative samples, a small number of maltreatment effects were studied.

In a recent Canadian study using a nationally representative sample of children reported for child maltreatment, Brown (2003) found that developmentally delayed children were more likely to be identified with behavior problems, irregular school attendance, negative peer involvement, violence toward others, and age inappropriate sexual behavior, than non-delayed children. Also, compared to non-delayed children, developmentally delayed children were more likely to be identified with health conditions, depression or anxiety, substance abuse-related birth defects, psychiatric disorders, and self-harming behavior. Non-delayed children were more frequently identified with substance abuse than delayed children. Although this study included more types of effects than previous research, it did not examine these effects among children with a variety of disabilities and it did not differentiate the effects across ages in children with and without disabilities.

Study Rationale and Hypotheses

To date, research suggests support for the hypothesis that maltreatment effects for children and adults with and

without disabilities are similar. Other researchers have implied that a variety of interactions between disability and abuse produce greater difficulties or qualitatively different responses. However, most of this research was based on American clinical samples or case studies. Furthermore, the limited number of types of disabilities, maltreatment effects, and little differentiation between ages on these effects are also limitations of previous research. Therefore, more systematic data collection and analyses should improve the generalizability of findings.

The present study improves on previous procedural limitations in several ways: (a) it uses a Canadian, nonclinical, representative sample of children and adolescents reported for child maltreatment; (b) it includes a variety of disabilities as one group; (c) it examines several effects that are consistent with those studied in the literature; and, (d) it uses specific age levels to differentiate any possible age effects of maltreatment among individuals with and without disabilities. Hence, such methodological improvements may further challenge the myth that persons with disabilities are not susceptible to effects of maltreatment and provide information about the risk of exhibiting clinical findings. The results would be useful for assessment, prevention and treatment of children with and without disabilities who are reported for maltreatment.

The following hypotheses are addressed in this study

(a) There will be no differences in the types of clinical findings identified for children without and with disabilities, (b) In comparing children with and without disabilities, there will be no differences in the proportions of children identified with various clinical findings and, (c) In comparing children with and without disabilities, there will be no differences in the proportions of children identified with various clinical findings across age levels.

Method

Data Collection

Data from the Canadian Incidence Study of Reported Child Abuse and Neglect (CIS) were used for this study. A four-stage stratified sampling design was used to select this nationally representative sample of children investigated for suspected maltreatment. (See Chapter 1, pp. 10-13 for a brief description of sampling design and data collection procedures.) A full description of the data collection procedures is available in Trocme et al. (2001).

Substantiated, suspected, and unsubstantiated child welfare investigations were included in the CIS. It did not include reports that were screened out before a full investigation, cases that were investigated only by police, new incidents of maltreatment on open cases at time of data collection, and incidents that were not reported to child welfare services (Trocme et al., 2001).

The CIS survey instruments were designed to capture

standardized information about children and their families from child welfare workers conducting investigations of reported maltreatment. The present study utilized information from the Intake Face Sheet and a component of the Child Information Sheet, the Child Functioning Checklist. This checklist was developed in consultation with child welfare workers as an index of the physical, emotional, cognitive, and behavioral issues that are often identified in child maltreatment investigations. Because the checklist items included only issues that child welfare workers became aware of during investigation, the original researchers believed that a more systematic assessment of issues would likely lead to identification of more issues than noted by workers during the study. Thus, the occurrence of child functioning problems is likely underestimated. However, it provides a first and important estimate of the types of issues that are identified during child maltreatment investigations (Trocme et al., 2001).

In using this checklist, investigating workers were asked to indicate problems that had been confirmed by a formal diagnosis or direct observation as well as issues that they suspected were problems, but could not fully verify at the time of investigation. For this study, the category "identified" was used because the distinction between confirmed and suspected was not documented in all jurisdictions (Trocme et al., 2001). Also, clinical findings in this study are listed as behavioral, physical,

emotional, and cognitive health issues in the CIS. The types of disabilities described in this study are categorized as physical, emotional, and cognitive health issues in the CIS.

Participants

The participants in this study include 7672 children from ages 0 to 15 years with a mean age of 7.5 years (SD=4.48). The data included a 15 year age limit due to varying definitions of "child" across jurisdictions. These children were noted for all types of maltreatment, including physical (34.7%), sexual (11.5%), neglect (50.7%), and emotional (29.5%). These percentages do not add up to 100% because children were identified for more than one category of maltreatment.

Children were further categorized into disabled and nondisabled groups. Children with disabilities (n=1067) included at least one of the following disabilities: (a) developmental delay, (b) physical or developmental disability (autism, paralysis, cerebral palsy, or learning disability), (c) other health condition (ongoing health concerns such as chronic illness or frequent hospitalizations), and (d) substance abuse related birth defects (Fetal Alcohol Syndrome, Fetal Alcohol Effects, cocaine addiction or solvent use by biological mother). These disabilities are generally considered to be developmental disabilities. According to the United States Developmental Disabilities Act, developmental disability is

defined as: a severe and chronic condition that is attributed to mental or physical impairment or their combination; occurs before age 21; is likely to be permanent; results is substantial functional limitations in at least three major life activities including self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living and economic self-sufficiency; and requires professional services that are of lifelong duration, planned and coordinated on an individual basis, and multi-disciplinary in nature (Graziano, 2002). This disabled group had a mean age of 7.03 years (SD=4.41).

Children without disabilities (n=6605) had a mean age of 7.57 years (SD=4.48) and included children who had showed no evidence of the disabilities previously described.

Results

Due to the categorical nature of the data, the following results involve a series of chi-square analyses. Table 4-1 describes the proportions of children without and with disabilities for each of the various types of clinical findings. These results tested the hypotheses: (a) there will be no differences in the types of clinical findings identified for children and adolescents without and with disabilities and; (b) in comparing children with and without disabilities, there will be no differences in the proportions of children identified for clinical findings.

Chi-square analyses were also conducted to compare and contrast the proportions of children without and with disabilities in each age level for each clinical finding (See Tables 4-2, 4-3, 4-4, and 4-5). These results test the last hypothesis that, in comparing children with and without disabilities, there will be no differences in the proportions of children identified with various clinical findings across age levels. The average number of clinical findings any child is likely to have also has been calculated.

Children of All Ages

Table 4-1 reports the percentages of children without and with disabilities and total children in the sample who were identified as having clinical findings.

Table 4-1

Percentages of Children without and with Disabilities and Total Children in Sample with Identified Clinical Findings

Clinical Finding	Disability		Total
	No	Yes	
Behavior Problem	19.7	33.3 ***	21.6
Depression or Anxiety	8.2	11.2 ***	8.6
Irregular School Attendance	6.0	10.0 ***	6.6
Negative Peer Involvement	5.8	10.2 ***	6.4
Violence to Others	4.3	9.2 ***	5.0
Running Away	3.7	3.7	3.7
Once	(1.7)	(1.5)	(1.7)
Multiple	(2.1)	(2.5)	(2.2)
Substance Abuse	3.3	3.0	3.3
Age Inappropriate Sexual Behavior	2.3	5.0 ***	2.7
Self-Harming Behavior	2.1	5.3 ***	2.5
Psychiatric Disorder	1.4	4.8 ***	1.9
One or More	29.5	44.8 ***	31.6

Note. Column percentages do not add up to percentages in the One or More column because children were identified in more than one category.

***p<=.001 (See text, p. 140 for X^2 values.)

Based on the total sample (n=7672), the most frequently identified clinical findings include behavior problem (21.6%), depression or anxiety (8.6%), irregular school attendance (6.6%), negative peer involvement (6.4%), and violence to others (5%). Running away, substance abuse, age inappropriate sexual behavior, self-harming behavior, and psychiatric disorder were identified less frequently, with each clinical finding being less than five percent. Although child welfare workers were required to document other specific concerns not listed on the Child Functioning Checklist, these types of concerns were only categorized as "other" in the CIS data. This "other" category did not specify those concerns and it was not included in the data analysis.

Children without disabilities show similar frequencies of clinical findings in Table 4-1. Specifically, they were most frequently identified for behavior problem (19.7%), depression or anxiety (8.2%), irregular school attendance (6%), negative peer involvement (5.8%), and violence to others (4.3%). Running away, substance abuse, age inappropriate sexual behavior, self-harming behavior, and psychiatric disorder were also the least frequent clinical findings among children without disabilities.

Table 4-1 shows that children with disabilities also were most frequently identified for behavior problem (33.3%), depression or anxiety (11.2%), irregular school attendance (10%), negative peer involvement (10.2%), and

violence to others (9.2%). Significant differences between the proportions of children with and children without disabilities were found for behavior problem, $X^2(1, N=7672) = 100.528$, $p<.001$, depression or anxiety, $X^2(1, N=7672) = 10.132$, $p=.001$, irregular school attendance, $X^2(1, N=7672) = 23.931$, $p<.001$, negative peer involvement, $X^2(1, N=7672) = 30.122$, $p<.001$, and violence to others, $X^2(1, N=7672) = 47.140$, $p<.001$. Also, compared to children without disabilities, children with disabilities also were significantly more likely to be identified for age inappropriate sexual behavior, $X^2(1, N=7672) = 25.511$, $p<.001$, self-harming behavior, $X^2(1, N=7672) = 39.236$, $p<.001$, and psychiatric disorder, $X^2(1, N=7672) = 58.524$, $p<.001$. There were no statistical differences between children without disabilities and children with disabilities regarding running away (3.7% for both groups) and substance abuse (about 3% for each group). Also shown in Table 4-1, a significant difference was found $X^2(1, N=7672) = 99.306$, $p<.001$ between children without disabilities and children with disabilities who were identified for at least one clinical finding.

Overall, the average number of clinical findings was found to be similar for the total sample (2.08), children without disabilities (2.05), and children with disabilities (2.22). Regardless of statistical probability, this difference would not be expected to have much clinical significance.

Children of Specific Age Levels

Chi-square analyses with clinical findings were conducted for specific age levels. The following is a discussion of these results.

Age level 0-3 years. Table 4-2 lists the percentages of children by disability status and total children in the sample aged 0 to 3 years who were identified as having clinical findings.

Table 4-2

Percentages of Children without and with Disabilities and Total Children at Age Level 0-3 with Identified Clinical Findings

Clinical Finding	Disability		Total
	No	Yes	
Behavior Problem	3.6	8.9 ***	4.4
Depression or Anxiety	1.5	1.8[a]	1.5
Violence to Others	0.7	1.8[a]	0.9
Age Inappropriate Sexual Behavior	0.7	0.0[a]	0.6
Running Away	0.4	0.4[a]	0.4
Once	(0.2)[a]	(0.0)[a]	(0.2)
Multiple	(0.3)[a]	(0.4)[a]	(0.3)
Self-Harming Behavior	0.1	1.4[a] ***	0.3
Psychiatric Disorder	0.2[a]	0.4[a]	0.2
Negative Peer Involvement	0.2[a]	0.0[a]	0.2
Substance Abuse	0.2[a]	0.0[a]	0.2
Irregular School Attendance	0.0[a]	0.4[a] *	0.1
One or More	6.1	11.3 **	7.0

Note. Column percentages do not add up to percentages in the One or More column because children were identified in more than one category.

[a] Cells with less than five expected frequencies.

*p<.05 **p<.01 ***p<=.001 (See text, pp. 143-144 for X^2 values.)

As shown for the total age group (n=1764), behavior problem (4.4%) and depression or anxiety (1.5%) were the most frequently identified clinical findings. The remaining clinical findings listed in the table were each identified at less than one percent.

Children without disabilities show a similar pattern of frequent clinical findings at this age level. Again, behavior problem and depression or anxiety were the most frequently identified clinical findings. Less than one percent of children without disabilities were identified for violence to others, age inappropriate sexual behavior, running away, self-harming behavior, psychiatric disorder, negative peer involvement, substance abuse, and irregular school attendance.

Compared to children without disabilities aged 0 to 3 years, children who had at least one disability were also more likely to be identified for behavior problem. This was found to be a statistical difference, $X^2(1, N=1764) = 15.682$, $p<.001$. Also compared to children without disabilities, children with disabilities were identified more frequently for depression or anxiety (1.8% vs. 1.5%), violence to others (1.8% vs. 0.7%), and self-harming behavior (1.4% vs. 0.1%). Only self-harming behavior showed statistical significance, $X^2(1, N=1764) = 11.514$, $p=.001$. The least frequent clinical findings for both groups include age inappropriate sexual behavior, running away, psychiatric disorder, negative peer involvement, substance

abuse, and irregular school attendance. A statistical difference, $X^2(1, N=1764) = 5.258$, $p<.05$, between children without and with disabilities was found for irregular school attendance. Differences for self-harming behavior and irregular school attendance need to be interpreted with caution due to low expected cell frequencies which results in low statistical power.

Over 11 percent of children aged 0 to 3 years with disabilities were identified for at least one clinical finding. This is almost double the percentage of children without disabilities identified for at least one clinical finding (6.1%). Chi-square analyses revealed this difference to be statistically significant, $X^2(1, N=1764) = 9.903$, $p<.01$.

Overall, the average number of clinical findings that children were likely to have did not vary for the total age group (1.33), children without disabilities (1.32), and children with disabilities (1.34). Again, this would not reveal any clinical significance.

Age level 4-7 years. Table 4-3 shows the percentages of children without and with disabilities and all children aged 4 to 7 years identified with clinical findings.

Table 4-3

Percentages of Children without and with Disabilities and Total Children at Age Level 4-7 with Identified Clinical Findings

Clinical Finding	Disability		Total
	No	Yes	
Behavior Problem	13.7	30.7 ***	16.1
Depression or Anxiety	4.5	5.8	4.7
Age Inappropriate Sexual Behavior	2.6	5.2 *	3.0
Irregular School Attendance	1.6	10.0 ***	2.9
Violence to Others	2.3	5.5 ***	2.8
Negative Peer Involvement	1.7	5.5 ***	2.3
Psychiatric Disorder	0.5	3.9[a] ***	1.0
Self-Harming Behavior	0.3	2.3[a] ***	0.6
Running Away	0.3	0.3[a]	0.3
Once	(0.1)[a]	(0.0)[a]	(0.0)
Multiple	(0.2)[a]	(0.3)[a]	(0.2)
Substance Abuse	0.2[a]	0.3[a]	0.2
One or More	20.4	43.7 ***	23.8

Note. Column percentages do not add up to percentages in the One or More column because children were identified in more than one category.

[a] Cells with less than five expected frequencies.

*p<.05 ***p<=.001 (See text, pp. 146-147 for X^2 values.)

This table shows that behavior problem (16.1%) and depression or anxiety (4.7%) were the most common clinical findings for children aged 4 to 7 years (n=2140). Age inappropriate sexual behavior, irregular school attendance, violence to others, and negative peer involvement were found to be between two and three percent. Psychiatric disorder, self-harming behavior, running away, and substance abuse were each at one percent or less.

Similarly, the most common clinical findings for children without disabilities were behavior problem (almost 14%) and depression or anxiety (4.5%). Percentages for age inappropriate sexual behavior, irregular school attendance, violence to others, and negative peer involvement range from 1.7% to 2.6%. The least common clinical findings, for children without disabilities aged 4 to 7 years, include psychiatric disorder, self-harming behavior, running away, and substance abuse. Each of the least frequent clinical findings was identified at less than one percent.

Compared to children without disabilities, children with disabilities aged 4 to 7 years were significantly more likely to be identified for behavior problem, $X^2(1, N=2140) = 57.107$, $p<.001$. Irregular school attendance was the next most frequent clinical finding (10%) for children with disabilities. This was also a statistical difference compared to children without disabilities, $X^2(1, N=2140) = 67.267$, $p<.001$. Children with disabilities were also identified more frequently for depression or

anxiety than children without disabilities, but no significant differences were found. Significant differences were found for age inappropriate sexual behavior, $X^2(1, N=2140) = 5.956$, $p<.05$, violence to others, $X^2(1, N=2140) = 10.147$, $p=.001$, negative peer involvement, $X^2(1, N=2140) = 16.653$, $p<.001$, psychiatric disorder, $X^2(1, N=2140) = 31.305$, $p<.001$, and self-harming behavior, $X^2(1, N=2140) = 16.440$, $p<.001$. Differences found for psychiatric disorder and self-harming behavior need to be interpreted with caution because low statistical power resulted from low expected cell frequencies in the chi-square analysis. Lastly, percentages of children with and without disabilities in this age group did not differ on clinical findings of running away and substance abuse.

A statistical difference was found, $X^2(1, N=2140) = 78.928$, $p<.001$ between children without and with disabilities who were identified as having at least one clinical finding. The average number of clinical findings was found to be similar for the 4 to 7 age group (1.43), children without disabilities (1.37), and children with disabilities (1.60).

Age level 8-11 years. Percentages of children without and with disabilities and all children aged 8 to 11 years with identified clinical findings are shown in Table 4-4.

Table 4-4

Percentages of Children without and with Disabilities and Total Children at Age Level 8-11 with Identified Clinical Findings

Clinical Finding	Disability		Total
	No	Yes	
Behavior Problem	22.3	50.2 ***	25.9
Depression or Anxiety	9.6	13.2	10.0
Negative Peer Involvement	5.3	15.6 ***	6.6
Violence to Others	5.1	15.6 ***	6.4
Irregular School Attendance	4.0	8.6 ***	4.6
Psychiatric Disorder	1.8	6.2 ***	2.4
Self-Harming Behavior	1.7	5.3 ***	2.2
Age Inappropriate Sexual Behavior	1.5	3.3[a]	1.8
Running Away	1.3	2.9[a]	1.5
Once	(0.6)	(1.6)[a]	(0.7)
Multiple	(0.8)	(1.2)[a]	(0.9)
Substance Abuse	0.9	1.2[a]	0.9
One or More	32.8	59.7 ***	36.2

Note. Column percentages do not add up to percentages in the One or More column because children were identified in more than one category.

[a] Cells with less than five expected frequencies.

***p<=.001 (See text, pp. 149-150 for X^2 values.)

In this age level (n=1876), the most frequently identified clinical findings include behavior problem (about 26%), depression or anxiety (10%), negative peer involvement, violence to others, and irregular school attendance (over 6% each). Psychiatric disorder, self-harming behavior (over 2% each), age inappropriate sexual behavior (1.8%), running away (1.5) and substance abuse (less than 1%) were the least frequently identified issues for children aged 8 to 11 years.

A similar pattern appears for children without disabilities in the 8 to 11 age level. They had slightly lower percentages for behavior problem (22.3%), depression or anxiety (9.6%), negative peer involvement (5.3%), violence to others (about 5%), and irregular school attendance (4%). The least frequent clinical findings for children without disabilities include psychiatric disorder, self-harming behavior, age inappropriate sexual behavior, running away, and substance abuse.

Behavior problem (50.2%) was the most common clinical finding identified for children with disabilities. This percentage was more than double the percentage of children without disabilities. Chi-square analyses revealed a statistical difference, $X^2(1, N=1876) = 85.875$, $p<.001$, for behavior problem. The next most frequent clinical findings were negative peer involvement and violence to others (over 15% each). Compared to children without disabilities, a statistical difference was found for negative peer

involvement, $X^2(1, N=1876) = 36.860$, $p<.001$, and violence to others, $X^2(1, N=1876) = 39.057$, $p<.001$. Although depression or anxiety was among the most common clinical findings identified for children with disabilities, a significant difference between children with and without disabilities was not found. There were significant differences found for irregular school attendance, $X^2(1, N=1876) = 10.122$, $p=.001$, psychiatric disorder, $X^2(1, N=1876) = 16.984$, $p<.001$, and self-harming behavior, $X^2(1, N=1876) = 13.075$, $p<.001$. No statistical differences were revealed for the least common clinical findings of age inappropriate sexual behavior, running away, and substance abuse.

About 33 percent of children without disabilities of the same age were identified for at least one clinical finding compared to almost 60 percent of children with disabilities. This difference was statistically significant $X^2(1, N=1876) = 66.280$, $p<.001$.

Generally, children with disabilities also were likely to have on average of 2.09 clinical findings. This average is slightly more than the average for children without disabilities (1.67) and the total 8 to 11 age level (1.76).

Age level 12-15 years. Table 4-5 displays the percentages of children by disability status and total children in the 12 to 15 year age level identified for different clinical findings.

Table 4-5

Percentages of Children without and with Disabilities and Total Children at Age Level 12-15 with Identified Clinical Findings

Clinical Finding	Disability		Total
	No	Yes	
Behavior Problem	38.4	49.1 **	39.7
Irregular School Attendance	18.5	23.9	19.2
Depression or Anxiety	17.1	28.3 ***	18.5
Negative Peer Involvement	16.0	23.9 **	16.9
Running Away	13.0	13.3	13.0
Once	(6.2)	(5.3)	(6.1)
Multiple	(7.3)	(9.7)	(7.6)
Substance Abuse	12.2	12.4	12.2
Violence to Others	9.0	16.8 ***	9.9
Self-Harming Behavior	6.2	14.6 ***	7.2
Age Inappropriate Sexual Behavior	4.1	12.8 ***	5.2
Psychiatric Disorder	3.0	10.2 ***	3.9
One or More	57.8	72.6 ***	59.6

Note. Column percentages do not add up to percentages in the One or More column because children were identified in more than one category.

**p<.01 ***p<=.001 (See text, pp. 152-153 for X^2 values.)

Overall, children in this age level (n=1853) were most likely to be identified for behavior problem (almost 40%), irregular school attendance (19.2%), depression or anxiety (18.5%), negative peer involvement (about 17%), running away (13%), and substance abuse (12.2%). They were least likely to be identified for violence to others, self-harming behavior, age inappropriate sexual behavior, and psychiatric disorder. These clinical findings were each identified at less than 10 percent for 12 to 15 year-olds.

For children without disabilities, the most frequently identified clinical findings were behavior problem (over 38%), irregular school attendance (18.5%), depression or anxiety (about 17%), and negative peer involvement (16%). Identical percentages to the total age level were found for running away and substance abuse. Violence to others, self-harming behavior, age inappropriate sexual behavior, and psychiatric disorder were the least frequent clinical findings for children without disabilities.

The most common clinical finding for children with disabilities aged 12 to 15 was behavior problem (almost 50%). This was found to be a statistically significant difference, $X^2(1, N=1853) = 9.490$, $p<.01$, when compared to children without disabilities at this age level. Depression or anxiety was the second most frequent clinical finding for children with disabilities. A significant difference, $X^2(1, N=1853) = 16.415$, $p<.001$, between children without disabilities and children with disabilities on this

clinical finding was revealed. Almost one quarter of children with disabilities were identified for irregular school attendance and negative peer involvement compared to 18.5 percent and 16 percent of children without disabilities. Only negative peer involvement showed a statistical difference, $X^2(1, N=1853) = 8.830$, $p<.01$. Also, compared to children without disabilities, those with disabilities aged 12-15 years were significantly more likely to be identified for violence to others, $X^2(1, N=1853) = 13.639$, $p<.001$, self-harming behavior, $X^2(1, N=1853) = 20.842$, $p<.001$, age inappropriate sexual behavior, $X^2(1, N=1853) = 30.672$, $p<.001$, and psychiatric disorder, $X^2(1, N=1853) = 27.280$, $p<.001$. No differences were found for children with and without disabilities for running away and substance abuse.

For one or more clinical findings, the difference between children with disabilities (72.6%) and children without disabilities (57.8%) was found to be statistically significant, $X^2(1, N=1853) = 18.027$, $p<.001$.

Children with disabilities aged 12 to 15 years had the highest average number of clinical findings (3.03) compared to children without disabilities (2.61).

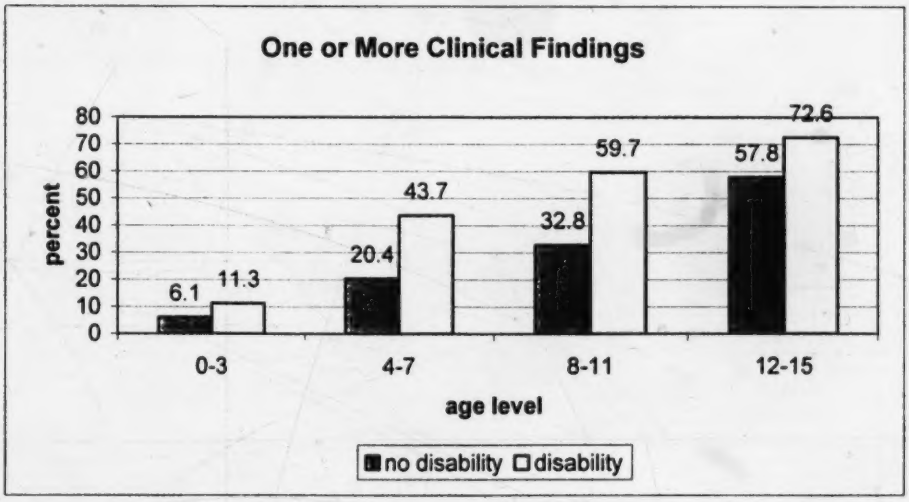
Effect of Disability and Age

Figure 4-1 illustrates the disability status by age interaction in a different manner. Figure 4-1 shows the percentages of children by disability status in each age level identified with at least one clinical finding.

Two patterns are illustrated. The first pattern shows disability effects. Compared to children without disabilities, there are greater percentages of children with disabilities who have at least one clinical finding, regardless of age. The second pattern shows age effects. The percentages of children with and without disabilities identified with at least one clinical finding increase as age increases. (See Appendix pp. 174-179 for individual clinical findings.)

Figure 4-1

Percentages of Children without and with Disabilities at Each Age Level with Identified One or More Clinical Findings



The results from Tables 4-2, 4-3, 4-4, 4-5 and Figure 4-1 show that children, particularly those with disabilities, are likely to have various clinical findings as they age. Thus, disability status appears to interact with age in the display of clinical findings.

Discussion

The general purpose of this study was to examine the types and proportions of identified clinical findings among children with and without disabilities. The results showed that, regardless of age, children with disabilities in this nationally representative sample were identified for all the same clinical findings as children without disabilities. Clearly, the most common clinical finding for both groups was behavior problem. Other common clinical findings were depression or anxiety, irregular school attendance, negative peer involvement, and violence to others. The least frequent clinical findings for children with and without disabilities included running away, substance abuse, age inappropriate sexual behavior, self-harming behavior, and psychiatric disorder. These results provide support for the first hypothesis, i.e., that there will be no differences in the types of clinical findings identified for children with and without disabilities.

Although there were similarities in the types of identified clinical findings between children with and without disabilities, significant differences in proportions between children with and without disabilities on all identified clinical findings were also found, except for running away and substance abuse. The similar or identical proportions for running away and substance abuse may be a function of opportunity and access for the children in this sample. Also, children with disabilities

were significantly more likely than children without disabilities to have at least one clinical finding. Generally, these results did not support the second hypothesis, i.e., in comparing children with and without disabilities, there will be no differences in the proportions of children identified for these clinical findings. Finally, the average number of clinical findings were about two for both groups, although it was slightly higher for children with disabilities.

Differences in proportions between children with and without disabilities became more clear when examining age levels. Children in the age level 0 to 3 years were basically asymptomatic, with the lowest proportions of identified clinical findings issues and an average of about one clinical finding for both children with and without disabilities. However, children with disabilities were more likely to be identified for behavior problem, self-harming behavior, and irregular school attendance. The last two issues were of low frequency and limited conclusions can be drawn for those results. For age levels 4 to 7 years and 8 to 11 years, significant differences were found on behavior problem, irregular school attendance, violence to others, negative peer involvement, psychiatric disorder, and self-harming behavior. Again, low frequencies limit any conclusions regarding significant differences found for psychiatric disorder and self-harming behavior. Children with disabilities aged 4 to 7 years were also significantly

more likely to be identified for age inappropriate sexual behavior than children without disabilities. This difference was not found for the 8 to 11 age level. Significant differences between children with and without disabilities aged 12 to 15 years were also found on the same clinical findings as the 4 to 7 and 8 to 11 age levels. Two exceptions included irregular attendance, where no difference was found for the 12-15 age level, and depression or anxiety, where a significant difference was found only for the age level 12 to 15 years. Overall, age level 12 to 15 years was the most symptomatic, with the highest proportions of children with and without disabilities identified for all clinical findings. These findings did not support the last hypothesis, i.e., in comparing children with and without disabilities, there will be no differences in the proportions of children identified with various clinical findings across age levels.

Furthermore, the differences between proportions of children with and without disabilities appear to increase with age, with the largest differences appearing in the 12 to 15 age level. The difference was largest in the 4 to 7 age level for irregular school attendance. Also, differences in proportions in the 8 to 11 age level were the largest for behavior problem, violence to others, running away, and negative peer involvement. Finally, compared to all age levels and children without

disabilities, children with disabilities aged 12 to 15 years had the highest average number of clinical findings.

Research, particularly empirical research, that examines effects of maltreatment among children and adults with disabilities is limited, yet some results of this study appear consistent with the existing literature. Regarding types of clinical findings, research without the use of control groups found behavior problems, aggressive behavior, self-abuse, suicidal tendencies, depression and anxiety, inappropriate sexual behavior, and psychiatric disorders among maltreated children with disabilities (Cook et al., 1993; Dunne & Power 1990; Burke & Bedard, 1995; Mansell et al., 1992). The finding of this study, greater frequency of behavior problems or "acting out" among children with disabilities, is consistent with Dunne and Power's hypothesis. This study did not measure for greater intensity or qualitatively different responses of children with disabilities, as indicated by Varley (1984), nor did the study determine if maltreatment may exacerbate disabilities (Bower Andrews & Veronen, 1993). However, the results of this study, showed that children with disabilities were identified significantly more often for psychiatric disorders than children without disabilities.

Research with the use of control groups found differences for children with disabilities on self-abuse and inappropriate sexual remarks/comments (Mansell et al., 1998), which are similar to Brown's (2003) results and the

findings of this study. Mansell and others (1998) also found no differences for aggressive behavior and differences for use/abuse of alcohol between children with and without disabilities. Such findings are inconsistent with the results of this study. These inconsistencies may be due to methodological differences, such as type and size of samples.

The results of this study are also consistent with Brown's (2003) study in which similar analyses were conducted using the same nationally representative data. There was one inconsistent finding. Although Brown found that non-delayed children were more likely to be identified for substance abuse than delayed children, this study did not find differences between children with and without disabilities on this clinical finding. This inconsistency may be due to the difference in the definition of disability used in each study.

Sullivan and Knutson (2000a, 2000b) found poorer school attendance among maltreated disabled runaways and maltreated disabled children. This present study also found that children with disabilities were significantly more likely to be identified for irregular school attendance than children without disabilities. Sullivan and Knutson found that running away is primarily an adolescent problem which is similar to the results of this study, in which running away was frequently identified for both children with and without disabilities, aged 12 to 15 years.

Finally, the researchers found that running away was associated with disability, which was not found in this study. The inconsistent findings may be attributed to definitional differences of disability and different samples. Sullivan and Knutson used school and hospital samples, which had less physical disabilities. The present study included more physical disabilities, which would limit opportunity to run away.

There is the myth that the effects of maltreatment on children with disabilities might be smaller because they are "damaged" or less sensitive to the effects (Sobsey & Mansell, 1990). Although this study did not determine cause and effect of maltreatment, this study found that (a) children with disabilities were identified for the same types of clinical findings as children without disabilities, and (b) the proportions of children with disabilities identified for a variety of clinical findings were generally greater than the proportions of children without disabilities, particularly across age levels. Thus, there is no support for the myth that children with disabilities are insensitive to pain. Consequently, these results point to the importance of assessment, prevention, and intervention with children with disabilities, who are reported for maltreatment, particularly because of certain vulnerability factors including limited social and communication skills, and dependency (Tharinger et al., 1990).

As with children without disabilities, assessment of children with disabilities reported for maltreatment involves the identification of signs of maltreatment. Recognition of maltreatment at an early stage can prevent an escalation of maltreatment, it can lead to referral for necessary intervention and may prevent the known negative effects in children exposed to chronic maltreatment (Ammerman & Baladerian, 1993). As shown in the results, the 0-3 year is mainly asymptomatic, but symptoms can occur at later ages (Allington-Smith, Ball, & Haytor, 2002).

The diagnosis of maltreatment can begin with recognition of physical signs such as inexplicable or unusual bruises and injuries, unkept appearance, poor hygiene, malnutrition, and sexually transmitted diseases (Ammerman & Baladerian, 1993). In the absence of physical signs, sudden behavior changes such as aggression, sexually inappropriate behavior, irregular school attendance, and self-harm, need to be recognized as possible indicators of maltreatment (Ammerman & Baladerian, 1993; Focht-New, 1996). Researchers suggested that behavior problems, including acting out, self-harm, and sexually inappropriate behavior, and psychiatric disorders may be a way to communicate or cope with maltreatment (Burke & Bedard, 1994; Dunne & Power, 1990; McCreary & Thompson, 1999; Sobsey & Mansell, 1990). Such behaviors in children with disabilities may be subtle and often be confused with behavioral features of the disability (Ammerman &

Baladerian, 1993; Allington-Smith et al., 2002). Thus, professionals need to be able to recognize and differentiate between maltreatment effects and disability effects (Focht-New, 1996). For example, Howlin and Clements (1995) used different assessment measures from people to determine changes in stress related behaviors and changes in autistic types behaviors. Because there is often no typical pattern of behavioral symptoms, professionals must compare current symptoms with previous functioning, gain a detailed history for the young person from other adults in child's life (Allington-Smith et al., 2002). Assessment for maltreatment also involves investigations of causes for behavior changes by asking questions of a variety of people in the child's life (Ammerman & Baladerian, 1993; Focht-New, 1996; Howlin & Clements, 1995).

Finally, it is important to have an awareness of occurrence and knowledge that persons with disabilities present a predictable pattern of signs similar to persons without disabilities (Ammerman & Baladerian, 1993; Cook et al., 1993). In addition, a cluster of symptoms are important to assess, not just a single indicator (Tharinger et al., 1990).

Several prevention methods are used in the area of maltreatment of children with disabilities. Child-centred programs teach children communication and self-protection skills, how to recognize abusive behavior, and identify feelings they may experience (Ammerman & Baladerian, 1993;

Sullivan, Knutson, Scanlan, & Cork, 1997). Increased supervision for children with disabilities, who may not be able to protect themselves or run away, would also be important (Dunne & Power, 1990). It is critical that the unique needs of children with disabilities are considered a part of any prevention program, including special education needs, medical and nutritional needs, and use of assisted devices and technologies (Ammerman & Baladerian, 1993).

Family-oriented programs help to provide support services to reduce incidence of physical abuse and neglect and improve parental awareness of risk factors associated with maltreatment among children with disabilities (Sullivan et al., 1997). Parent training courses can include topics on communication, behavior management, and household organization (Ammerman & Baladerian, 1993).

In terms of treatment, no single treatment strategy will be suitable for every child (Allington-Smith et al., 2002). Programs need to be developmentally appropriate and sensitive, particularly to the communication difficulties of children with a variety of disabilities (Levey & Lagos, 1994). Action methods, play or art therapy, music therapy, role playing, use of photographs or sketches, picture boards, picture books from magazines, drawings or photographs for a child who uses gestures to communicate, are important for children who have limited communication skills and require other means of communication (Focht-New, 1996; Hurley, Tomasulo, & Pfadt, 1998; Sullivan & Scanlan,

1990). Group psychotherapy has also been recommended when it is appropriate to the child's needs (Ammerman & Baladerian, 1993; Hurley et al., 1998; Focht-New, 1996). Given that older children with disabilities were most likely to be identified for depression or anxiety should alert clinicians to the need for comprehensive assessment and appropriate treatment for these children.

A multidisciplinary, competency based treatment approach attending to the needs of the child, parents, and family unit is recommended. Children are offered counselling and skills training through individual and/or group sessions. Parents are trained in relaxation, parenting and behavior management skills, and social interactive skills. Such an approach needs to involve coordination of related services to further facilitate therapeutic needs (Levey & Lagos, 1994).

Some limitations of the findings need to be considered. First, no specific criterion level was used to judge statistical significance since current statistical authorities argue against using prespecified criteria (Shadish, Cook, & Campbell, 2002). Each of the five tables contains multiple comparisons for individual clinical findings and a summary variable indicating one or more of these clinical findings. In view of the fact that 10 clinical findings are evaluated in each table, the probability levels should be viewed conservatively. Individual clinical findings with probability levels

greater than .01 should be considered with particular caution.

A second limitation has to do with the design of the study, which may not clarify some possible confounding results. Because the study is not designed to determine cause and effect, there may be some confounding between having a disability and behavior problems or other clinical findings. If children are identified as having a disability because they are exhibiting behavior problems, then children with disabilities will appear to have more behavior problems than children without disabilities. The greater proportions of children with disabilities identified for various clinical findings may be related to the disability itself. Hence, children with behavior problems because of a disability may not be accurately detected for signs of maltreatment.

Finally, the proportions children with and without disabilities aged 0 to 3 years identified for various clinical findings were not zero as one might expect. As examples, children with and without disabilities were identified for depression or anxiety (1.8% and 1.5%, respectively), violence to others (1.8% and 0.7%), and self-harming behavior (1.4% and 0.1%). Because most of these clinical findings are not clearly defined in the CIS, it is unknown how the social workers interpreted these items on the Child Functioning Checklist when collecting data.

Conclusion

This present study was designed to compare and contrast types and proportions of children with and without disabilities on identified clinical findings. Children with disabilities were found to have the same types of clinical findings as children without disabilities, but at significantly greater frequencies. Assessment, prevention, and treatment efforts for these children need to involve their unique needs and adaptive methods are required to meet those needs.

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APPENDIX

Figures of Disability and Age Effects

Figure 4-2

Percentages of Children without and with Disabilities at Each Age Level with Identified Behavior Problem

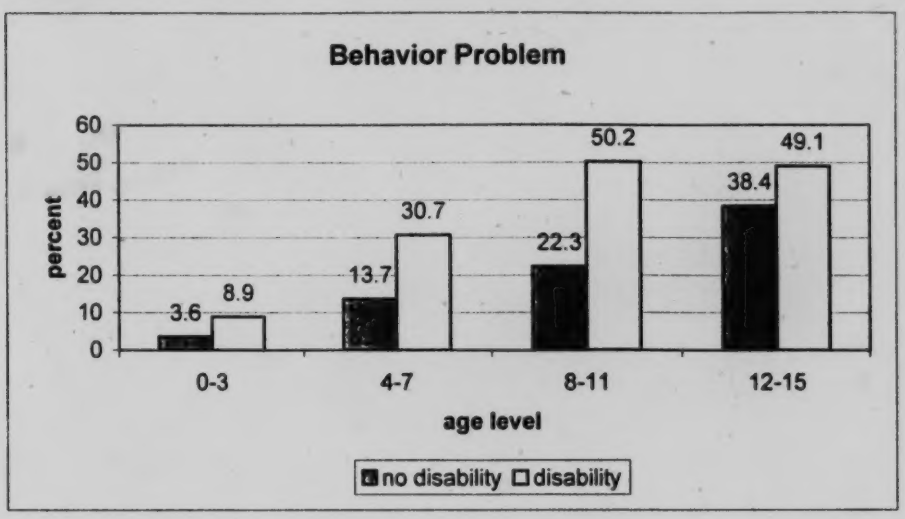


Figure 4-3

Percentages of Children without and with Disabilities at Each Age Level with Identified Depression or Anxiety

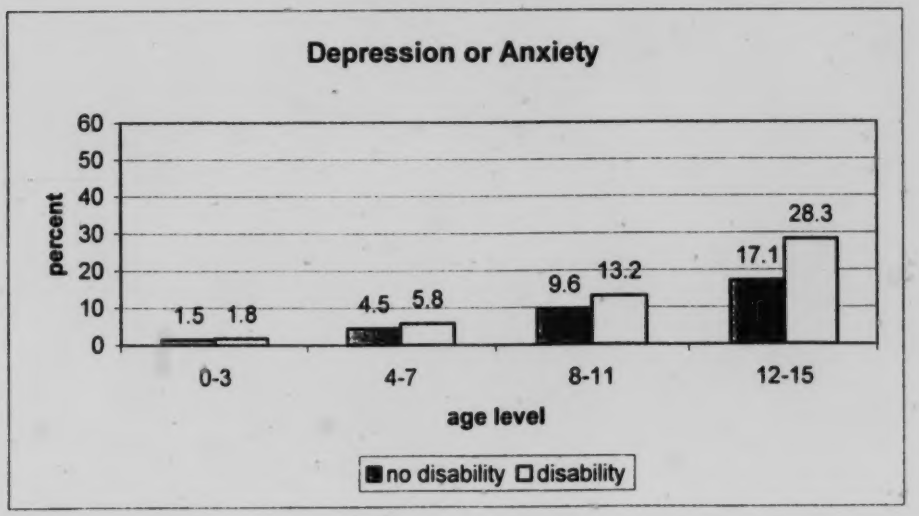


Figure 4-4

Percentages of Children without and with Disabilities at Each Age Level with Identified Irregular School Attendance

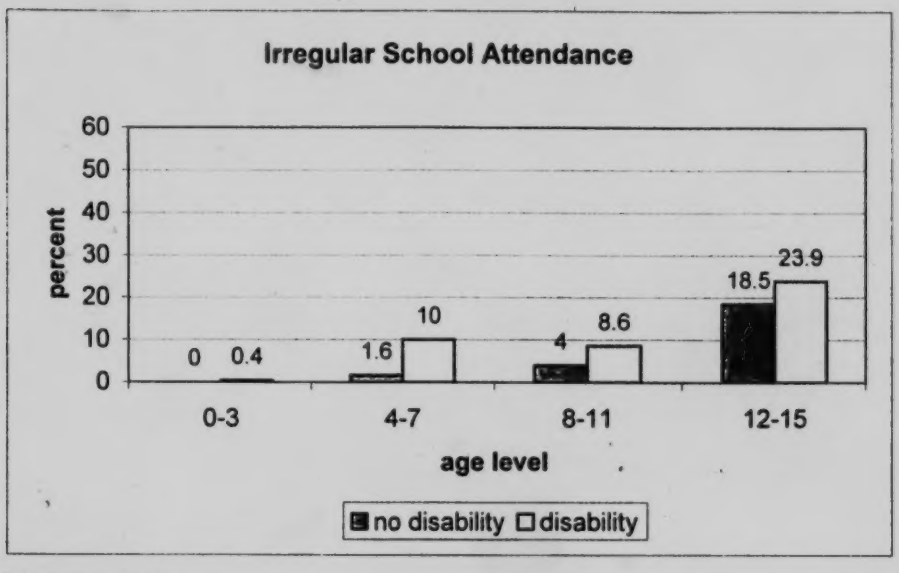


Figure 4-5

Percentages of Children without and with Disabilities at Each Age Level with Identified Negative Peer Involvement

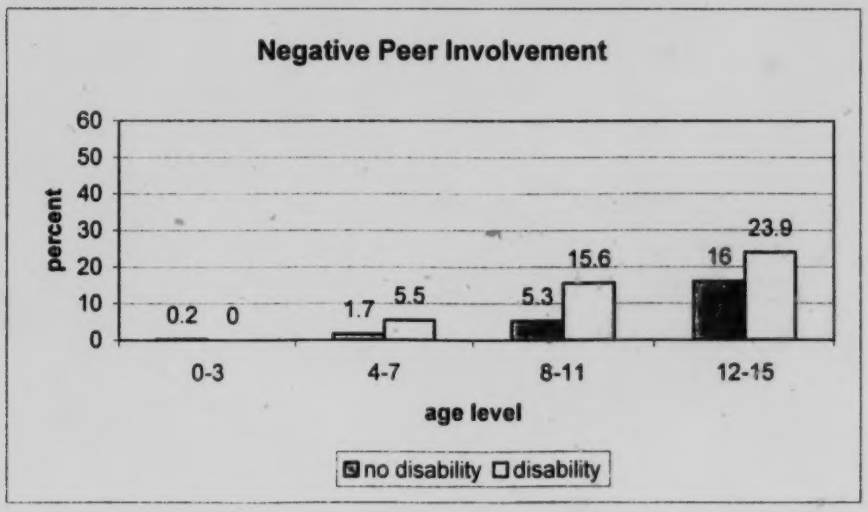


Figure 4-6

Percentages of Children without and with Disabilities at Each Age Level with Identified Violence to Others

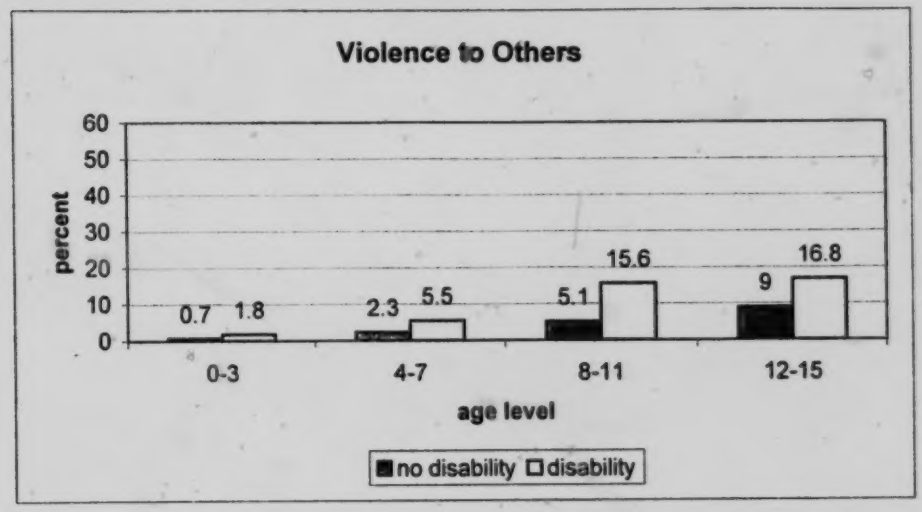


Figure 4-7

Percentages of Children without and with Disabilities at Each Age Level with Identified Self-Harming Behavior

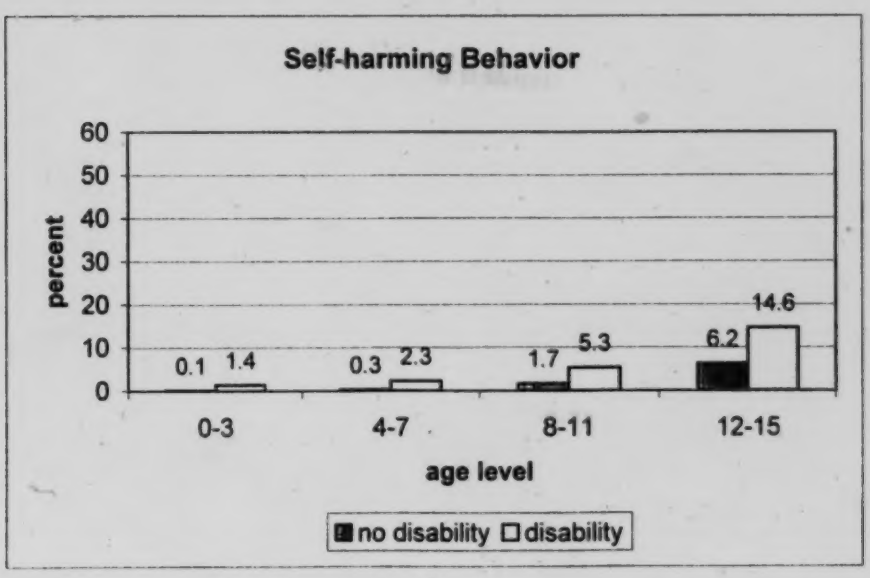


Figure 4-8

Percentages of Children without and with Disabilities at Each Age Level with Identified Running Away (Once)

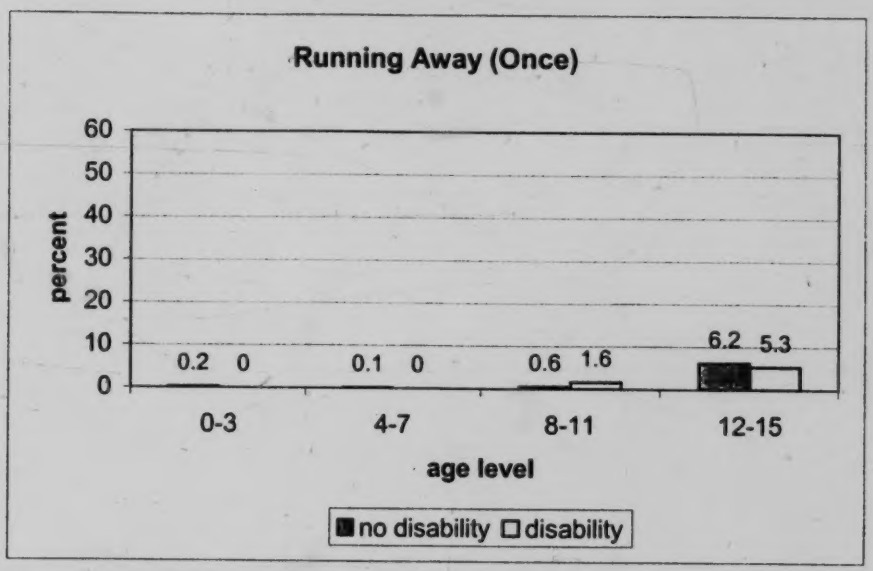


Figure 4-9

Percentages of Children without and with Disabilities at Each Age Level with Identified Running Away (Multiple)

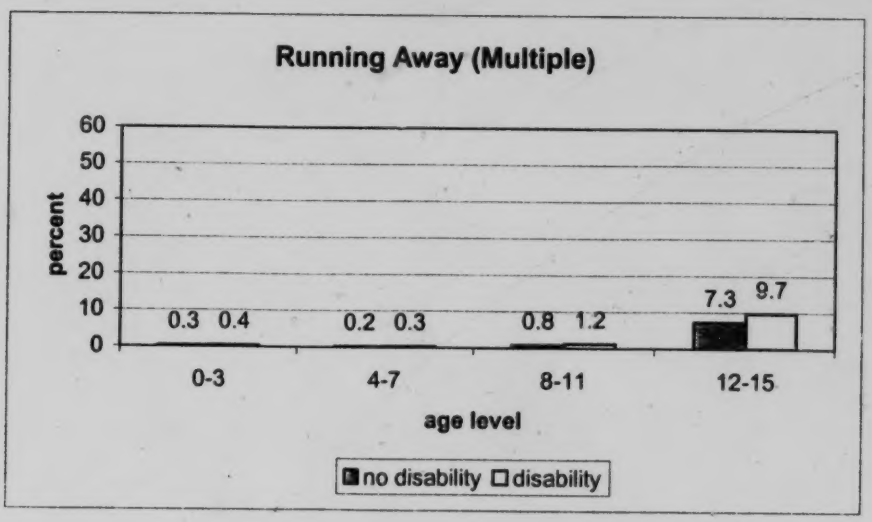


Figure 4-10

Percentages of Children without and with Disabilities at Each Age Level with Identified Running Away (Either)

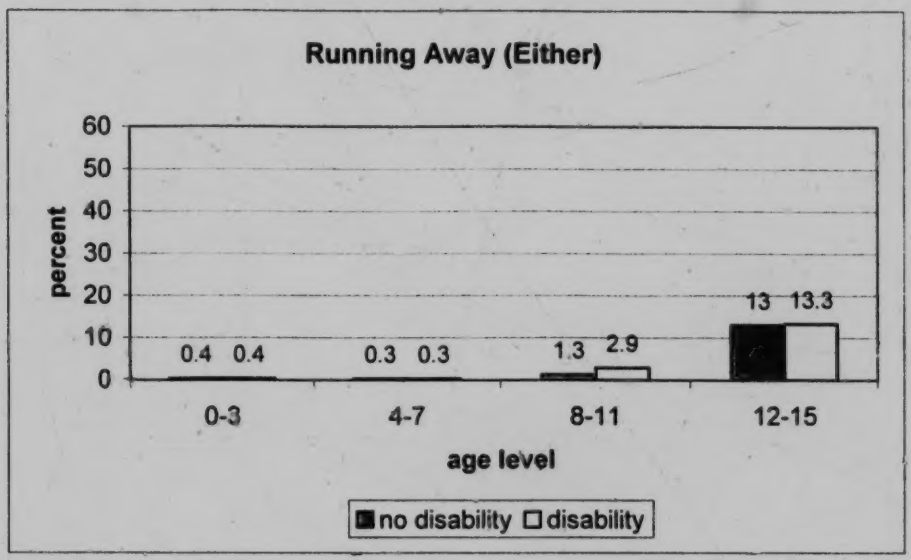


Figure 4-11

Percentages of Children without and with Disabilities at Each Age Level with Identified Substance Abuse

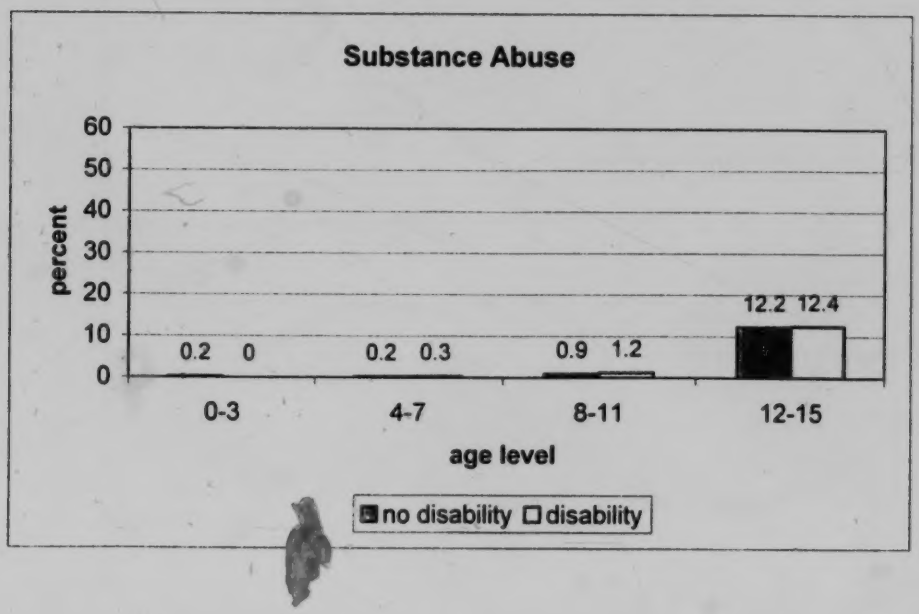


Figure 4-12

Percentages of Children without and with Disabilities at Each Age Level with Identified Age Inappropriate Sexual Behavior

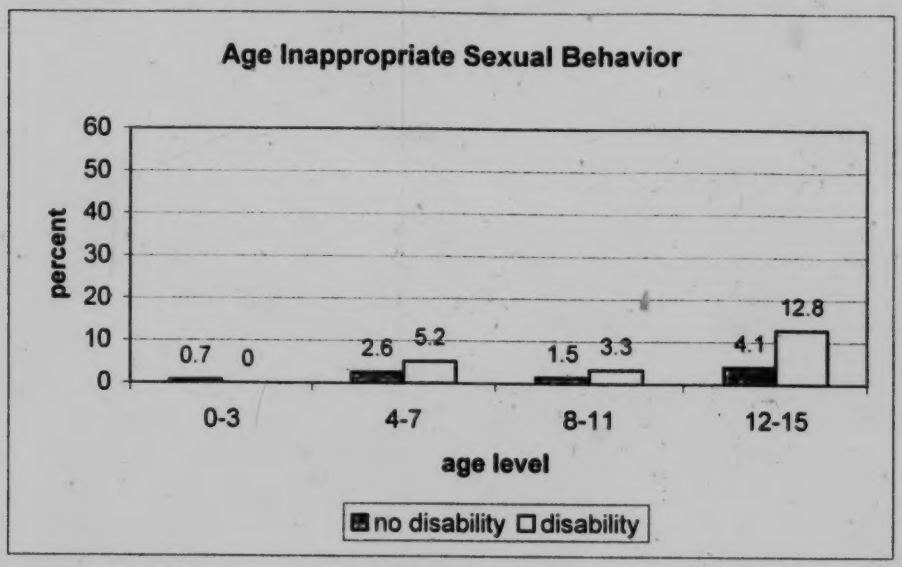
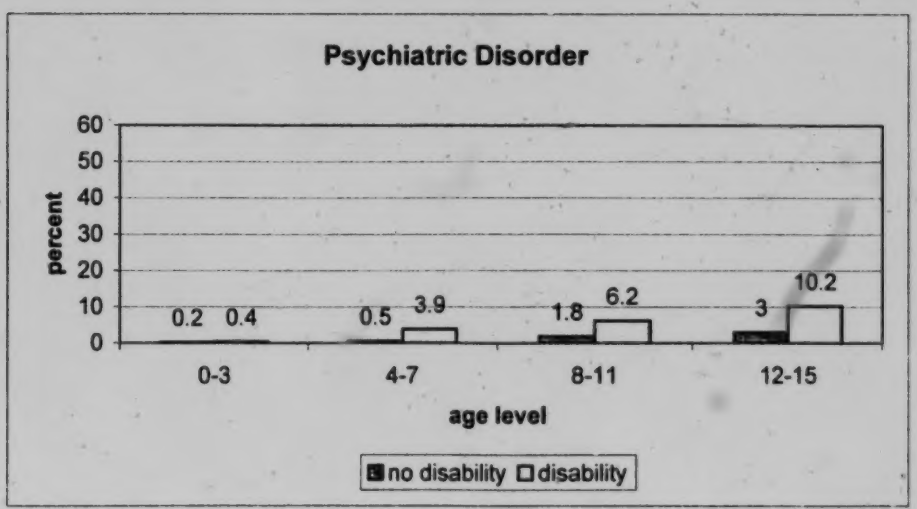


Figure 4-13

Percentages of Children without and with Disabilities at Each Age Level with Identified Psychiatric Disorder



CHAPTER 5

Conclusion

There can be no doubt that the occurrence of child maltreatment represents a gross violation of the rights of a vulnerable and dependent child (Cicchetti & Toth, 1995). This is particularly true for children with disabilities who are at increased risk for maltreatment. Although a significant amount of research has been conducted on the etiology and sequelae of child maltreatment, it is only by enhancing our understanding of etiology, building on our knowledge of the negative effects of maltreatment on the process of development, that a unified, comprehensive plan of action capable of addressing the complexity of child maltreatment will emerge (Cicchetti & Toth, 1995). The following section summarizes the findings on individual characteristics related to potential consequences of maltreatment and cultural attitudes as they relate to disinhibition of violence.

Summary of Findings

Using a nationally representative sample of children reported for maltreatment, child characteristics of age and disability and their role in possible consequences of maltreatment, were examined in Chapters 3 and 4. The study described in Chapter 3 found that proportions of children identified for specific clinical findings and disabilities were different in four specific age levels. Proportions of children identified for behavioral, cognitive, and emotional clinical findings increased across age levels, whereas

proportions of children identified for physical, developmental, other health conditions, and substance abuse-related disabilities decreased across age levels. The study in Chapter 4 examined the proportions of children with and without disabilities identified for the same behavioral, cognitive, and emotional clinical findings as in Chapter 3. It was found that children with disabilities were identified with the same types of clinical findings as children without disabilities. Furthermore, greater proportions of children with disabilities were identified for these clinical findings than children without disabilities. In both studies, both groups of children aged 0 to 3 years were less likely to be identified with clinical findings; however, the proportions of children identified with clinical findings increased with age. This was particularly the case for children with disabilities. Hence, age and disability were found to be important individual characteristics in examining possible consequences of child maltreatment.

Risk factors for child maltreatment were described in Chapter 2. In particular, it was emphasized that cultural attitudes, beliefs, and values can influence one's behavior, especially violence against children with disabilities. Bandura's (1990) theory of mechanisms of moral disengagement was applied to explain how various cognitive mechanisms, including devaluation, dehumanization, and blame, contribute to the disinhibition of violence against children with disabilities. In this paper's discussion, children with disabilities are considered to (a) have less valuable lives

because they are believed by the nondisabled majority to have a low quality of life, (b) be viewed by society as less than human and without the capacity to feel pain, and (c) be seen as provoking maltreatment and stressful burdens for their families. Counselling families of children with disabilities was discussed in terms of supporting a healthy adjustment process, and viewing these families as being part of or being initiated into a new culture. Thus, cross-cultural counselling of families involves the importance of examining individual attitudes prior to working with families who have children with disabilities and ways to be ethically competent in counselling these families.

Taken together, this thesis highlights the need for the consideration of various contexts in the nature and consequences of child maltreatment.

Examining Findings from a Developmental-Ecological Perspective

In this chapter, an attempt is made to describe Belsky's (1993) developmental-ecological model, that was introduced in Chapter 1, and relate this model to Chapters 2, 3, and 4. A developmental-ecological perspective can be useful as a guide to understand the contexts or factors that are important for explaining child maltreatment. Belsky's (1980) model describes the contexts which are influential in the etiology of maltreatment. A 1993 version of his model further describes developmental and ecological aspects. Child characteristics include age, physical health, and behavior. Parent context includes parental history,

psychological resources, and personality characteristics. Community context includes different supports and services for families. The societal-cultural context involves the attitudes, beliefs, and values which embed people, households, and neighbourhoods. Finally, the evolutionary context includes the conditions that amplify biological conflicts of interest between parent and child. The developmental component of Belsky's (1993) model includes the child and parent factors, and the ecological component includes the community, societal-cultural, and evolutionary contexts of child maltreatment. This thesis investigated child characteristics of age and disability, and the cultural aspects of attitudes, beliefs, and values.

When looking at Belsky's (1993) model and the research conducted for this thesis, a developmental component to explaining possible effects of child maltreatment is necessary. Since the proportions of children, regardless of disability status, identified for various clinical findings had increased across age levels, it becomes clear that age influences changes in experiencing possible maltreatment effects. The finding that children with disabilities were more likely to be identified for a variety of clinical findings, particularly over age levels, suggests that disability is another important characteristic in influencing possible sequelae of child maltreatment. Thus, children change developmentally over time, which, in turn, influences clinical findings related to maltreatment.

With regard to the cultural attitudes, including

devaluation, dehumanization, and blaming, a developmental component to explaining violence against children with disabilities is also necessary. Since devaluation increases the risk for maltreatment, devaluation may be influenced by age and disability, which further increase the risk for maltreatment. Because all infants are dependent on caregivers, regardless of disability status, their risk for maltreatment is about equal. However, the risk for maltreatment may increase as a child with disabilities ages and begins to display what people may view as a poor quality of life with little value. Some disabilities, such as learning disabilities, may not be apparent until school age. Once a child displays learning disabilities in school, a child's life may not be valuable to others because they may see that child as having lower potential for a meaningful life. For infants with moderate or severe disabilities, such as Down syndrome (e.g. Affleck, 1980; Shaw, Randolf, & Manard, 1977), their risk for maltreatment may be higher because their lives may be viewed by others as "damaged" and not have any value. Hence, age and disability may interact to influence devaluation and increase a child's risk for maltreatment.

Like devaluation, dehumanization may be influenced by age and disability. For example, a preschool-aged child with mild disabilities may be viewed as similar to a preschool-aged child without disabilities because the differences may not be obvious to other people. As the child with disabilities ages, features of disabilities may become more

obvious. When disabilities are more noticeable, others' perception of differences may increase which further increases social distance from the child and the child's risk for maltreatment. Using Bogdan, Brown, and Foster (1992) as an example, infants with disabilities labeled as "nonviables," "fetuses," or "chronics" may already be viewed as different or less than human compared to infants labeled as "good babies." As a result, infants with disabilities may be more likely to experience maltreatment because their differences are obvious at their young age. Again, age and disability may interact to influence dehumanization by emphasizing any differences and increase a child's risk for maltreatment.

Similarly, blame may have a developmental component in its role for increasing a child's risk for maltreatment. As children with disabilities age, parents may perceive them as provoking abuse and ongoing sources of stress. Babies communicate their needs by crying. With age, they eventually develop other skills, such as language, and behaviors to communicate their needs. Children with disabilities may have limited ways of communicating their needs and may behave in ways that are related to their disability. Caregivers may interpret such behavior as abuse provoking (Rusch, Hall, & Griffin, 1986). Infants with severe disabilities may be viewed as a burden and sources of stress (Forest, 1991). They may be blamed for being a "burden" or causing stress, and are at increased risk for maltreatment. Thus, age and disability may interact to influence blame and increase a

child's risk for maltreatment.

Overall, Belsky's developmental-ecological perspective provides a framework to link together and understand the results of this thesis. The results show that possible effects and risk factors of child maltreatment are influenced by child characteristics of age and disability. However, Belsky's developmental component is not found in counselling practice. Therefore, assessment, prevention, and intervention efforts need to consider age and disability as variables in addressing child maltreatment. The following section describes assessment, prevention, and intervention with a focus on a developmental approach when working with maltreated children experiencing potential consequences of maltreatment, and families who have children with disabilities. Ecological aspects relevant to counselling practice are also discussed.

Implications for Practice

Consequences of child maltreatment manifest themselves differently according to numerous factors, including the child's developmental level. Methods of documenting harm will need to vary with the child's age if possible sequelae are to be assessed accurately (Cicchetti & Toth, 1995). Also, there is the need to consider disability status in the effects of maltreatment. Development of some children with disabilities may not match with developmental milestones of children without disabilities. That is, developmental level is not necessarily synonymous with chronological age (Cicchetti & Toth, 1995). Developmental level and disability

status need to be considered in order to accurately assess the specific needs of maltreated children.

Such accurate assessment leads to comprehensive and coordinated prevention and treatment services that include knowledge of how maltreated children negotiate stage-salient issues of development (Cicchetti & Toth, 1995). Stage-salient issues continue to evolve across the life span, and new strengths and/or vulnerabilities can emerge at any time (Cicchetti & Toth, 1995). For example, a child who appears asymptomatic immediately after the identification of maltreatment may show symptoms over time with the increasing sophistication in certain domains of development (Shirk, 1988). Studies in this thesis found that children with and without disabilities aged 0 to 3 years were mainly asymptomatic, but older children with and without disabilities were identified for a variety of clinical findings. To prevent future social, emotional, and cognitive difficulties, prevention services for maltreated children, who are not manifesting difficulties, and their families need to be considered (Cicchetti & Toth, 1995). Services may include supportive services, home visitation programs, and training in child development and parenting skills (Cicchetti & Toth, 1995). Prevention services need to incorporate developmentally appropriate approaches to meet children's and their families' needs at the earliest stages.

In treating maltreated children, James (1989) emphasized the importance of providing developmentally sequenced treatment. Such sequenced treatment is required

because past traumatic events will have different or additional meaning to children as they mature, which can impair any progress of development (James, 1989). According to Shirk (1988), whatever the stage at which a child may have experienced maltreatment, effects will usually be expressed through behaviors or symptoms specific to the current stage of development.

Upon entering therapy, clinicians must first conduct a comprehensive assessment of the effects of maltreatment and plan a treatment strategy aimed at the identified problem areas at the child's current stage of development (Cicchetti & Toth, 1995). In addition to assessing all areas of functioning, the impact of the developmental process on the emergence of sequelae needs to be considered (Cicchetti & Toth, 1995; Shirk, 1988). It is important to have available therapy during periods well beyond the occurrence of the maltreatment experience (Cicchetti & Toth, 1995). For example, a preschool child who has completed a successful course of therapy by showing a decrease in aggressive behavior may need to re-enter therapy if impaired self-esteem in the form of self-blame or depression surfaces in later years (Cicchetti & Toth, 1995; Shirk, 1988). Shirk (1988) labels this process "developmental symptom substitution." Therefore, treatment approaches to child maltreatment need to utilize developmentally appropriate approaches to meet children's needs at current and future stages of development.

According to Cicchetti & Toth (1995), a primary issue

to consider when providing therapy to a maltreated child, regardless of disability status, involves the need to address the ecology of the maltreatment experience. In individual therapy, it is important to remember that the child does not exist in isolation, but continues to be affected by the home, school, and broader community. The current environment, whether the child remains in the care of a maltreating family or has been removed to an alternate placement, must be considered during treatment and is likely to affect the response to treatment (Cicchetti & Toth, 1995).

Removal of maltreated children to alternate placements is another issue that counsellors need to be aware of during treatment. From a child protection services perspective, keeping the child in the family is often the preferred choice, provided that there are reasonable grounds to believe the child is safe and there are attempts within the family to improve the home situation. For example, there may be child maltreatment and other issues, such as substance abuse or spousal violence, occurring in families. Counsellors may play a role in helping families of maltreated children to improve their situation by providing counselling for these issues and other support services, including parent skills training and follow-up services (Cicchetti & Toth, 1995).

Children with disabilities may be more likely to be removed from the home due to neglect, but permanent placements for them may be difficult to find because they

may require special care. Consequently, these children are more likely to be sent to live with foster care families. The placement of children with disabilities in several foster care families on a rotating basis can increase their risk of meeting potential offenders. Removal of children with disabilities from their natural homes may not necessarily be in their best interests, unless there are adequate and effective supports in the community. In cases of removal, counsellors can serve as a major support to the child during a difficult transition (Cicchetti & Toth, 1995). From a developmental-ecological perspective, the removal of maltreated children from their homes involves the consideration of the children's needs and the kinds of community supports available to help these children and their families.

Another aspect of the ecology of maltreatment that counsellors need to consider is the relationships in the child's life (Cicchetti & Toth, 1995). A counsellor must evaluate the availability of positive relationships that the maltreated child has with a grandparent, teacher, friend, or some other influential person. Whether or not the child has ever experienced a positive relationship will serve as a marker of the likelihood of the child's being receptive to forming a therapeutic relationship. Knowledge of the child's history of relationships and developmental needs may guide the therapist in determining whether to use a relationship-based type of therapy or behaviorally-oriented techniques (Cicchetti & Toth, 1995). Furthermore, the counsellor can

communicate with the child's teacher to address any behavioral problems or school difficulties, and help to promote a positive school environment for the child (Cicchetti & Toth, 1995). Belsky's model may help guide counselling interventions by highlighting the influence of important persons in a child's life at that particular age and context.

A developmental-ecological approach is also applicable to working with families of children with disabilities. Families may seek counselling after their child is newly diagnosed or once the child enters school. Risk factors for maltreatment may vary for the child based on the child's age and severity of disability. Children with disabilities may be at risk for being devalued, dehumanized, and blamed early in their lives, whereas others may not be at risk until their disabilities become more obvious as they age and develop. As a result, these families' needs may vary.

To address families' needs, family-focused interventions can be used to facilitate children's developmental progress through satisfying and nurturing relationships in the family. These interventions emphasize child developmental levels, family interaction patterns, and family needs, and use individualized family programs based on child and family needs, family cultural values and belief systems, and goals (Bailey et al., 1986; Caro & Derevensky, 1991). In families with young children who have developmental disabilities, it was found that marital adjustment was linked to positive overall family functioning

(Trute, 1990). Researchers have found that families who have children with disabilities can improve their situation over time with appropriate training, planning, and support (Caro & Derevensky, 1991). Therefore, counselling parents who have children with disabilities needs to incorporate the early assessment of child, parent, and marital characteristics and an evaluation of cultural aspects which influences family members' behavior.

The results of this thesis also emphasize the need for flexible approaches to dealing with child maltreatment. Because diversity exists with regard to etiological factors that contribute to the occurrence and perpetration of maltreatment, treatment effectiveness is also likely to vary (Cicchetti & Toth, 1995). Since there is not a "typical" maltreated child, one treatment paradigm will unlikely meet the needs of all maltreated children. In all interventions, research on the sequelae of maltreatment should be known and incorporated into planning and implementation (Cicchetti & Toth, 1995). Eclectic approaches are required to best suit the needs of children and adolescents, particularly those with disabilities.

In summary, the developmental-ecological perspective highlights the complex interrelationships between the developmental and ecological contexts in understanding child maltreatment. This perspective can illustrate how these contexts influence risk factors and consequences of child maltreatment. Specifically, this thesis addressed the influential role of child characteristics of age and

disability, and cultural attitudes, values, and beliefs in the nature and possible consequences of child maltreatment. The developmental-ecological perspective and the findings of this thesis can enhance prevention and intervention programs by identifying different requirements, risk factors, and potential maltreatment effects among children of different age levels and disability status.

Implications for Research

Because the CIS dataset did not include children who were non-maltreated, the studies in this thesis did not compare maltreated and non-maltreated children of different age levels. To clarify more precisely the effects of maltreatment, future research needs to compare maltreated and non-maltreated children of different ages on effects and disabilities in a nationally representative sample. Future research also needs to compare maltreated and non-maltreated children with and without disabilities on effects of maltreatment in a nationally representative sample.

It was unclear how the child welfare workers collected information on identified clinical findings for the 0 to 3 year-old age level in the dataset. Future research needs to use more clearly defined criteria that specify the kinds of clinical findings that are common at this young age level. Such clarification would provide more understanding about the kinds of clinical findings that need to be addressed in prevention efforts.

In addition to clarifying clinical findings, future research needs to use specific criteria to define disability more clearly. For instance, the types of disabilities described in the CIS are not independent from each other. (See Appendix, p. 200 for Table 5-1.) This overlap shows that there is not a reliable differentiation between these disability categories. Furthermore, the disability categories in the CIS are not defined in the same manner that school professionals and clinicians use these terms. For example, Sullivan and Knutson (2000a, 2000b), used definitional criteria for disability based on special educational requirements. In the CIS, the difference between developmental delay and developmental disability is not clear. Because these disability categories overlap, the "One or More" variable used as a summary variable in Chapters 3 and 4, describes this overlap the best.

This lack of clarity in the definitions of disability types means that the CIS data cannot be statistically compared to other datasets. For example, Statistics Canada (2002) reported that developmental disabilities affected 29.8% of children with disabilities aged 5 to 14 years. This compares to 3.4% of children aged 0 to 15 in the CIS data. Also, Statistics Canada (2002) reported that developmental delay affected 68% of children with disabilities aged 0 to 4 years. In the CIS data, almost 9% of children aged 0 to 3 years were identified as having developmental delay. Although Statistics Canada (2002) and the CIS use the disability categories "developmental disabilities" and

"developmental delay", different criteria to categorize children may have been used. Also, Statistics Canada (2002) did not report any information on children 0 to 4 years categorized as having developmental disabilities. Hence, specific and consistent criteria for disability and age levels would allow for more comparisons across datasets.

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APPENDIX

Combinations of Disabilities

Table 5-1

Percentages of Children in Sample with Combinations of Disabilities

Disability Combination	%
Developmental Delay	
Only*	6.2
+Developmental/Physical Disability	1.1
+Other Health Conditions	0.5
+Substance Abuse-Related Birth Defects	0.2
+Other Health Conditions	0.7
+Substance Abuse-Related Birth Defects	0.1
+Substance Abuse-Related Birth Defects	0.6
Developmental/Physical Disability	
Only*	1.7
+Other Health Conditions	0.2
+Substance Abuse-Related Birth Defects	0.0
+Substance Abuse-Related Birth Defects	0.1
Other Health Conditions	
Only*	2.8
+Substance Abuse-Related Birth Defects	0.1
Substance Abuse Related Birth Defects	
Only*	1.1
All four	0.1

* Only refers to cases that do not include any of the other disabilities